HERTFORDSHIRE safeguardingchildren PARTNERSHIP

CHILD DEATH REVIEW AND RESPONSE ARRANGEMENTS

RAPID RESPONSE PROTOCOL

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I N D E X

HERTFORDSHIRE SAFEGUARDING CHILDREN PARTNERSHIP (HSCP)

CHILD DEATH REVIEW AND RESPONSE ARRANGEMENTS

RAPID RESPONSE TO UNEXPECTED CHILD DEATH PROTOCOL

INTRODUCTION

The following procedures detail the Hertfordshire Safeguarding Children Partnership (HSCP) multi-agency response to the sudden or unexpected death of a child. They should be followed by all professionals in conjunction with any relevant policies, procedures and protocols of their own agency.

The majority of sudden unexpected deaths in infancy or childhood have natural causes and are unavoidable tragedies. The incidence of unexpected deaths in infancy or childhood is highest in infancy. About 600 babies die suddenly each year in the UK.

Professionals from a number of different agencies and disciplines will become involved following an unexpected death in infancy or childhood to try to establish the cause of the death and support the family. This protocol is intended to provide guidance to the professionals confronted with these tragic events. It is acknowledged that each death has unique circumstances and each professional has their own experience and expertise to draw on in their handling of individual cases. There are however common aspects to the management of unexpected death in infancy or childhood and it is important to achieve good practice and a consistent approach.

All professionals need to strike a balance between managing the sensitivities of a bereaved family and identifying and preserving anything that may help to explain why the child died. It is as important to absolve a family from blame and to recognise medical conditions, especially hereditary disorders, as to identify unnatural deaths or homicides.

DEFINITION

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

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

(Working Together 2018)

APPLICATION

These procedures are applicable to the sudden or unexpected death of a child, up to their 18th birthday, of any natural, unnatural or unknown cause, at home, in hospital or in the community.

The Rapid Response protocol need not be applied to deaths where the cause is known, e.g. following a diagnosed disease, such as pre-diagnosed meningitis, or is obvious, e.g. road traffic collision.

Where there is any doubt about whether a death is unexpected these procedures should be followed. It is advised that professionals responsible for end of life care of a child with a life limiting condition identify, document and regularly review the circumstances in which these

procedures will not be applied. It should be ensured that the child's family and all staff involved in the care are aware of these decisions.

These procedures are primarily applicable to deaths occurring in Hertfordshire but will also be applied to deaths occurring elsewhere consequent to a sudden unexpected event in Hertfordshire. It will, however, normally be most appropriate for the Local Safeguarding Children's Board (LSCB) child death arrangements where the death occurred to provide the initial response.

Similarly, it will normally be appropriate for the initial response to a death occurring in Hertfordshire consequent to a sudden unexpected event elsewhere to be provided by the HSCP, under these procedures, with the further management of the response being undertaken by the LSCB for the area where the event occurred.

In such cases close liaison and cooperation between the child death response arrangements of the respective LSCB is essential to ensure a coordinated approach and agree appropriate management of the response. The place where the child is normally resident and any agreement between the respective Coroners on jurisdiction should be considered in deciding which LSCB should have primacy.

FRAMEWORK FOR THE RESPONSE TO A SUDDEN OR UNEXPECTED CHILD DEATH

These procedures contain general guidance for all professionals involved in the response to the sudden or unexpected death of a child, information about individual agency responsibilities and details of the multi-agency arrangements for the longer term management and assessment of the death.

The HM Coroner must be informed according to the "The Notification of Deaths Regulations 2019" (see Appendix 13) at the earliest opportunity and, by law, this must also be done in writing. The HM Coroner has control of what happens to the child's body and decides which pathologist will complete the post-mortem examination.

Individual cases can always be discussed with a Trust Medical Examiner (if available), HM Coroner's Officer or, in an emergency, with the HM Coroner directly. The HM Coroner should normally be contacted via the HM Coroner's Officer.

Multi-agency working will always involve at least HM Coroner, Police, Health and Social Care professionals. Other agencies involved with the family also have a contribution to make.

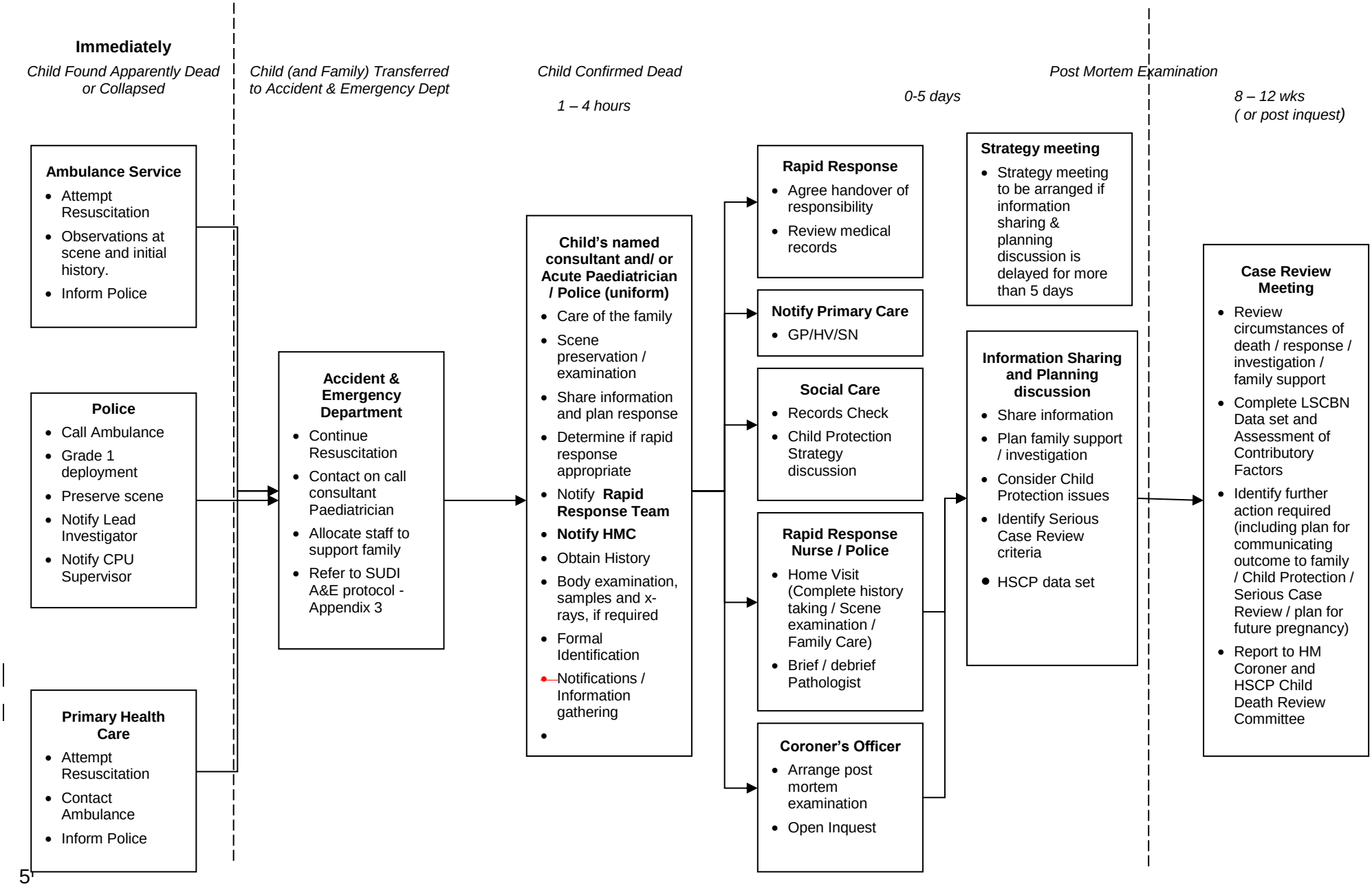
Each professional must be fully conversant with both their own agency's responsibility and the responsibilities of the other agencies. There should be collaborative and coordinated working at all levels from the earliest call to the emergency services.

The key events described in these procedures are:

- Transfer of the child to an Accident and Emergency Department
- Initial response and early investigation
- Early inter-agency information sharing and planning
- Hospital procedures
- Joint Health Service/ Police home visit
- Liaison with HM Coroner and Post Mortem examination arrangements
- Multi-agency review and planning arrangements

The pathway through these events is shown in Figure 1

FIGURE 1 – FLOWCHART OF RESPONSIBILITIES



RELATIONSHIP TO OTHER PROCEDURES

These procedures are complimentary to and will operate in parallel with or contribute to a number of other processes. These may include:

- Coroner's inquests
- Medical Examiner scrutiny
- Criminal investigations
- Serious Case Reviews
- Child Protection (Section 47) investigations
- Health and Safety Executive Investigations
- Health Service Serious Untoward Incident investigations
- Provision of Social Care services to family members
- Provision of primary care and/or hospital treatment to family members
- LSCB Child Death Review arrangements
- Prison Service investigations
- Independent Police Complaints Commission investigations

Following the sudden or unexpected death of a child the Police, acting on behalf of HM Coroner or in the investigation of a crime have primacy in the investigation. Notwithstanding this, all professionals should work within these procedures and ensure that the interface between them and other processes is appropriately managed.

PRINCIPLES

The following principles should be adhered to by professionals from all agencies:

- Ensuring that bereaved families are treated with sensitivity and respect, offered appropriate support and kept fully informed.
- Adopting an open minded, proportionate and professional approach to the circumstances.
- Effectively working together and sharing information within a multi-agency response.
- Ensuring that evidence is preserved and that the death is thoroughly investigated.
- Providing a prompt response and ensuring that the investigation is completed expeditiously.

GENERAL GUIDANCE

The unexpected death of a child is a traumatic time for everyone involved. The family will be experiencing extreme grief and shock. Professionals will need to support the family and although the time spent with them may be brief, actions may greatly influence how the family experiences the bereavement for a long time afterwards.

It is the right of every child to have their death properly investigated. Families also desperately want to know what happened, how the event could have occurred, what the

cause of death was and whether it could have been prevented. If another child death occurs in the family, a carefully conducted investigation of an earlier death is extremely helpful.

The majority of child deaths occur as a result of natural causes or accidents. Some of these will however have medical implications for other family members or have been contributed to by potentially avoidable factors. In addition, a minority of child deaths are the consequence of, or associated with, abuse or neglect.

The response of all agencies to the death of a child must therefore keep a sensitive balance between a sympathetic and supportive approach to the family and maintaining professionalism towards the investigation.

Unless there are clear and compelling reasons to the contrary, it is inherent in these procedures that all children who die suddenly or unexpectedly in the community are transferred to a hospital Accident and Emergency Department. This is regardless of whether the chances of successful resuscitation are thought to be negligible, and specifically so that the response to the death may be effectively managed in accordance with these procedures.

When the Police are concerned that a death may be due to intentional harm, it is important that these procedures are still applied and that all agencies co-operate closely and jointly to determine how best to proceed with the investigation and support of the family.

All professionals must record any information provided by parents, carers or other family members in as much detail as possible. The initial accounts about the circumstances, including timings, must be recorded accurately, contemporaneously and preferably verbatim.

Where the use of any recording equipment is contemplated to assist in the later recall and documenting of information provided by the family, this should only be carried out with the knowledge and agreement of all persons present and the Police Investigating Officer. Any recordings made must be preserved and once used for their primary purpose retained by the Police.

All entries on medical records and other documents relating to the deceased child must be legibly signed, timed and dated, include role or designation and be and clearly attributable to their author.

The following advice is provided for professionals dealing with the family of a child who has died, particularly in the early stages of their bereavement.

- When you arrive always say who you are, why you are there, and how sorry you are about what has happened to the child.
- The family will be in the first stages of grief and may react in a variety of ways, such as shock, numbness, anger or hysteria. Allow the family members space and time to cry, to talk together and to comfort any other children. These moments of grieving are very important.
- 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, albeit with observation by an appropriate professional.
- In talking about the child preferably use the first name, or, if you don’t yet know the name, say ‘your son/daughter’. Don't refer to the child as ‘it’.
- Have respect for the family's religious beliefs and culture. Such issues must be handled sensitively but not to the detriment of the investigation.
- If English is not the family’s first language an interpreter should be arranged.

- Take things slowly, allowing the family members to gather their thoughts and tell the story in their own way.

- 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 them again. They may also need advice and assistance with funeral arrangements and what to do with their other children.
- Most parents feel guilty when their child has died. When talking to them try to ask questions in a neutral way, e.g. 'Would you like to tell me what happened?' Avoid questions that sound critical, such as 'Why didn't you?'
- At all times be sensitive in the use of mobile phones and other communication equipment. Whenever possible, whilst remaining contactable, such equipment should be turned off when with the family.
- Don't use such phrases as 'suspicious death' or 'Scenes of Crime Officer', and try to avoid comments that might be misunderstood by, or distressing to, the family.
- Parents need to understand the role of the coroner, and the need for a detailed multi-disciplinary investigation, which will include obtaining a comprehensive medical history, a visit to the place where the collapse or other event leading to the death occurred, post mortem examination and meetings between the professionals involved.
- Do not ask their permission for a post mortem but explain sensitively what is involved.
- Parents should be told that they will be informed of the initial post mortem result and other information as it becomes available, but that the final cause of death may not be established for a few weeks or even months.
- Parents need to know to whom they can turn for help and support in their bereavement.
- Written contact names and telephone numbers should be given to the parents

FACTORS THAT MAY AROUSE SUSPICION

Certain factors in the history or examination of the child may give rise to concern 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 and relevant professionals in other key agencies involved in the investigation. The following list is not exhaustive and is intended only as a guide.

- Previous child deaths in the family. Two or more unexplained child deaths occurring within the same family is unusual and should raise questions both about an underlying medical or genetic condition as well as possible unnatural events.
- Previous and current child protection concerns within the family relating to this child or any siblings.
- Inconsistent information. The account given by the parents or carers of the circumstances of the child's death should be documented verbatim. Inconsistencies in the story given on different occasions or to different professionals should raise suspicion, although it is important to be aware that inconsistencies may occur as a result of the shock and trauma of the death.

- Inappropriate delay in seeking help.
- Evidence of drug, alcohol or substance misuse, particularly if the parents are still intoxicated or sedated.
- Evidence of parental mental health problems.
- Previous episodes of unexplained illness, such as cyanotic episodes or brief, resolved, unexplained events (BRUE), previously known as acute life threatening events (ALTE).
- Neglect. Observations about the condition of the accommodation, cleanliness, adequacy of clothing, bedding and the temperature of the environment in which the child is found are important. A history of previous concerns about neglect may be relevant.
- Evidence of physical abuse/unexplained injuries, 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.
- 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 the 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.

However the following should be noted and are present in many infant deaths:

- Froth emerging from the mouth and nose. This froth results from the expulsion of air and mucus from the lungs after death. Sometimes the froth may be blood-stained: this does not mean that the death was unnatural.
- Small quantities of gastric contents around the mouth. This does not mean that death was caused by inhalation of vomit. Often there is slight regurgitation after death.
- Purple discoloration of the parts of the face and body that were lying downwards. This is not bruising, but is caused by the draining of blood in the skin after death. For the same reason the parts that were lying upwards may be very pale.
- Covering of the child's head by the bedclothes. This has often been a feature of cot death in the past, and probably contributes to death through accidental asphyxia or overheating.
- Wet clothing or bedding. This is usually caused by excessive sweating before death.
- If the child looks as though he/she has been roughly handled, remember that this may be the result of attempts at resuscitation.

Each individual agency/service will have specific responsibilities in relation to an unexpected death. These are set out as appendices to the main protocol.

INTER-AGENCY WORKING

Information Sharing and Planning Discussion

A multi-agency Information Sharing and Planning Discussion will be convened by the Rapid Response Nurse within 3 -5 days of the child's death. If the decision is made to combine

with the Strategy meeting this should not be delayed and would usually be held within 24 hours of the death.

If the discussion is to take place as a meeting it should be held at the family GP's surgery. The Rapid Response Nurse will arrange for the discussion to be minuted and for these to be distributed as soon as possible. Any disagreement with the content of the minutes should be raised with the Rapid Response Nurse immediately.

This meeting will be chaired by the Rapid Response Nurse and may include:

- The child's / patient named consultant, Acute Paediatrician and/ or other Consultant who knows the child and family prior to the death.
- A resuscitation team member, either a paediatrician or senior nurse
- The paramedic/s who attended the scene
- The health professional who visited the home address.
- The child's GP.
- The child's paediatrician if relevant
- The child's Health Visitor/ School Nurse
- The Pathologist information wherever possible
- Children Social Care representative
- The Police Investigating Officer
- A Coroner's Officer.
- A representative from any School, College or Nursery attended by the child.
- Any other relevant professional providing services to the child or family/school or community
- Where the child was normally resident in and / or the event leading to the death took place in another LSCB area, appropriate professionals from the other area(s).

The purpose of this meeting is to:

- Share information held by all agencies in current or previous case notes or other records.
- Coordinate agency contribution to and involvement in the investigation of the child's death.
- Ensure a co-ordinated bereavement care plan is in place for the family.
- Explicitly consider whether there are any child protection risks to siblings or other children in the household.
- Explicitly decide whether the circumstances should be referred to the LSCB for consideration of holding a Serious Case Review.
- Ensure that all relevant agencies and professionals have been notified of the child's death.
- Agree what information from the meeting will be shared with the family and who will provide this to them. Generally there should be complete openness with the family unless this could undermine a criminal or child protection investigation.

- Where the child was normally resident in and / or the event leading to the death took place in another LSCB area, coordinate the respective LSCB child death response arrangements and the involvement of agencies in each of the areas. Whichever LSCB is to take primacy in the investigation these arrangements should include provision of the LSCB Core Data Set and final report on the death to the LSCB Child Death Review Committee.

If any child protection risks are identified during or prior to the meeting it will adopt the dual function of a formal child protection strategy meeting. The area team and Head of Child Protection at Hertfordshire Children Social Care should be notified and if out for hours then the Emergency Duty team should be contacted.

At or after the discussion the Rapid Response Nurse will complete of the HSCP Child Death Review reporting form (Appendix 12), if this has not already been completed. When the form is completed it will be forwarded to the Child Death Overview Panel (CDOP).

If the initial results of the post mortem examination are not available at the time of the discussion a contingency should be agreed for when they are available. In most cases this will involve telephone contact between relevant professionals but in some circumstances, (e.g. if the post mortem examination identifies abuse of the child) it will be more appropriate for the Rapid Response Nurse to re-convene the meeting.

Following the meeting the identified professional will provide the family with the information agreed.

Case Review Meeting

A multi-agency Case Review Meeting may be convened by the Rapid Response Nurse as soon as possible after the final post mortem result is available (the timing will vary according to circumstances, but should be no more than 8 – 12 weeks after the death). The timing of this meeting will need to be discussed with the HM coroner's office.

There will be times that a case review meeting may not be required, but this needs to be agreed by the Rapid Response Nurse in agreement with the members of the initial information sharing and planning discussion. The rationale for this should be documented within the minutes of the initial meeting.

There may be times that a review meeting did not appear necessary at the initial meeting but further information develops that leads to the need to reconvene a review meeting by the Rapid Response Nurse.

Whenever possible, the meeting should be held at the family GP's surgery.

The Rapid Response Nurse will arrange for the meeting to be minuted. Any disagreement with the content of the minutes should be raised with the Rapid Response Nurse.

This meeting will be chaired by the Rapid Response Nurse and where appropriate will include:

- The Consultant Paediatrician, designated doctor for child death or other Acute Consultant representative
- The paramedic/s who attended the scene
- The health professional who visited the home address.
- The child's GP.
- The child's Health Visitor/School Nurse.

- The Pathologist wherever possible.
- Children Social Care representative
- The lead Police Investigator
- A Coroner's Officer.
- A representative from any School or Nursery attended by the child.
- Any other relevant professional providing services to the child or family.
- Where the child was normally resident in and / or the event leading to the death took place in another LSCB area, appropriate professionals from the other area(s).

The purpose of this meeting is to:

- Review all relevant information concerning the death, the child's history, family history and subsequent investigation.
- Review all relevant information concerning the death, the child's history, family history and subsequent investigation.
- Ensure that no information has been overlooked. Any further tests or opinions which may shed light on the cause of death may be recommended to the appropriate agency.
- Explicitly comment on the presence or not of concerns about abuse and neglect causing or contributing to the death. If there is no evidence of maltreatment this should be documented.
- Explicitly consider whether there are any unaddressed child protection risks to siblings or other children in the household and if so what action should be taken and by whom.
- Review the effectiveness of the response provided by agencies and professionals to the death and identify any elements of good practice or potential lessons to be learnt
- Comment on the quality of any services provided by agencies to the child and / or family prior to the death and identify any elements of good practice or potential lessons to be learnt.
- Explicitly decide whether the circumstances should be referred to the HSCP Local Child Safeguarding Practice Review Panel' for consideration of holding a Practice Review.
- Agree how accurate and appropriate information regarding the findings of the investigation will be shared with the family and by whom. Generally there should be complete openness with the family unless this could undermine a criminal or child protection investigation.
- To review whether the support and guidance for the family is adequate and to plan for counselling and any further services required.
- Consider the need, and if so prepare a plan for any future pregnancies.
- Where the child was normally resident in and / or the event leading to the death took place in another LSCB area, consider the information needs of the HSCP and how these will be addressed. This will normally be through providing copies of the documents prepared for the HSCP.
- The Hospital will ascertain whether bereaved parents would like to see the hospital paediatricians to discuss details of their child and offer support

- Ascertain who the parents would like to feed back to them the results of the post-mortem. Options include the Police Family Liaison Officer, the GP, the Rapid Response Nurse, the Coroner's Officer, the Consultant Paediatrician, the Designated Doctor for SUDIC or any combination of the above.

When appropriate, this meeting will mark the closure of the investigation into the child's death. The precise timing will depend on the progress of the Police/Coroner investigations.

Families should be provided with information from the meeting at the earliest opportunity, usually by the Rapid Response Nurse or the clinician responsible for the child's care and a member of the primary health care team.

Where the Police and / or Social Care are conducting a criminal and / or child protection investigation, the Rapid Response Nurse should discuss with the lead professional for the relevant agency(ies) what information should be shared, how and when? Where a Police Family Liaison Officer has been appointed the involvement of that professional in this process should be considered.

Following the multi-agency Case Review Meeting the Rapid Response Nurse will provide an agreed record of the meeting and all reports to HM Coroner.

APPENDICES

Each individual agency / service will have specific responsibilities in relation to an unexpected death. These are set out as appendices to the main protocol

- Appendix 1 Ambulance Service
- Appendix 2 General Practitioners / Health Visitors / Community Nursing Staff
- Appendix 3 East & North Herts and West Herts Hospital Trusts (Hospitals)
- Appendix 4 Health Services / Rapid Response Team
- Appendix 5 Police
- Appendix 6 Social Care
- Appendix 7 Coroner's Officer And Pathologist
- Appendix 8 Information To Be Collected At The First Interview And The Home Visit
- Appendix 9 Proforma
- Appendix 10 Support links
- Appendix 11 Skeletal Survey
- Appendix 12 Core Data Set

APPENDIX 1 - AMBULANCE SERVICE

This section should be read in conjunction with the General Guidance above and applied in the context of the procedures applicable to other agencies.

Following receipt of a call to the Ambulance Emergency Control Centre (EOC) the nearest available emergency response will be sent to the scene, supported by additional resources as required.

The recording of the initial call to the ambulance service should be retained in case it is required for evidential purposes. Call logs can be requested via the appropriate channels. The Ambulance Control Centre will immediately notify the Police Force Control Room when there is a call to the scene of a child in cardiac arrest, an unexpected child death and this is reported by the attending ambulance staff. The member of staff calling should confirm the Trust is responding to such a call ad provide known details at that time. If you reach scene and the police are not en-route please make sure you request them to attend. If you are actively resuscitating and there is a delay from the Police do not delay on scene. Update EOC if you are leaving for the Emergency Department (ED).

Resuscitation should be attempted in all cases, unless there is a condition unequivocally associated with death or a valid advance decision (Do Not Resuscitation (DNR). Ambulance personal refer to their Joint Royal College Ambulance Liaison Committee (JRCALC) for protocols.

If you commence Basic Life Support/Airway Life Support you must not stop. These patients must be pre-alerted to the nearest ED with rapid conveyance.

All children will be taken to the Accident and Emergency Department, unless they have obviously been dead for some time and the circumstances of death pre-set a clear and compelling reason for the body to remain at the scene until released by the Police.

If there is a condition unequivocally associated with death or valid advance decision resuscitation would not be appropriate. This should be discussed with the family, in most circumstances, it will still be appropriate to transfer the child and family to an Accident and Emergency department with paediatric facilities where the joint agency response may be initiated, the child can be examined and appropriate immediate medical investigations carried out.

If there are immediate indications of abuse, neglect or an assault contributing to the death, the Police should take the lead in the management, under the direction of an investigating officer. In such circumstances, and if the child is clearly dead, it may not be appropriate to move the child and the scene should be secured as for any potential crime scene.

All children must be taken to the Accident & Emergency Department. The child should <u>not</u> be taken straight to the mortuary even if they appear to have been dead for some time and the fact of death has been confirmed before arrival at the hospital.

It is good practice to ensure where possible the patient is not transported across County boundaries.

The Accident and Emergency Department should be informed, giving an estimated time of arrival and the child's condition. This should be a pre-alert call from the scene.

The family should also be taken to the hospital to ensure receipt of appropriate medical and social support. Please consider the needs of siblings and other family members.

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. Good clear documentation is paramount

Any persons remaining at the scene should be asked not to disturb or move items around where the child was found until it has been seen by the Rapid Response Nurse and/or Police. It should be stressed that this can be extremely important in helping the family to understand why the child has died.

If the circumstances allow, any comments made by the carers or others present, any background history, any possible drug misuse and the conditions of the living accommodation should be noted.

The patient clinical record is to be completed in full as a record of attendance and treatment of the patient. Printouts from any monitoring equipment used should be retained with the record. All information from the scene and any concerns should be reported directly to the Police and to the receiving doctor at the hospital as soon as possible. All child deaths must have a Single Point Of Contact (SPOC) referral, this is to include any sibings within the household.

If in exceptional circumstances the child's body is to remain at the scene the ambulance staff should await the arrival of the Police Investigating Officer.

A representative of the Ambulance Service will always be invited to the multi-agency Information Sharing and Planning Discussion and Case Review Meeting.

APPENDIX 2 - GENERAL PRACTITIONERS / HEALTH VISITORS / COMMUNITY NURSING STAFF

This section should be read in conjunction with the General Guidance above and applied in the context of the procedures applicable to other agencies.

Occasionally the GP, Health Visitor or Community Nurse will be the first professional to attend the scene of the unexpected death of a child. In general the same guidance applies to these professionals as the Ambulance Service.

Primary healthcare professionals should not assume death and unless clearly inappropriate they should clear the airway and apply full cardiopulmonary resuscitation. An emergency ambulance should always be called to the scene. The healthcare professional present should also contact the police.

The professional should be aware that ambulance staff will take the child to the Accident and Emergency Department rather than to the mortuary, even when the fact of death has been confirmed at home or elsewhere. It is preferable that verification of death is deferred until the child is transferred to the local Accident and Emergency Department.

Primary healthcare staff is very important in supporting the family following the death of a child. They should visit the family at home as soon as is convenient and will be involved in providing ongoing advice, support and counselling for the family, in collaboration with other professionals. This process will be coordinated as detailed below in the inter-agency working section of these procedures. **A GP should not issue the death certificate in these circumstances.**

Additional guidance for primary healthcare staff, particularly in relation to the longer term care of the family, is available from the Lullaby Trust

Primary healthcare staff should make notes available to the professionals involved in the investigation of the child's death and promptly complete requested documentation requested by the Child Death Overview Panel (eg. Child Death Reporting form, (Previously known as Form B).

Those involved with the family will always be invited to the multi-agency Information Sharing and Planning Discussion and Case Review Meeting and should attend wherever possible

APPENDIX 3: EAST & NORTH HERTS AND WEST HERTS HOSPITAL NHS TRUSTS.

Introduction

This section should be read in conjunction with the General Guidance above and applied in the context of the procedures applicable to other agencies.

These procedures will be followed when a child dies within a hospital in Hertfordshire or is brought to an Accident and Emergency Department having died in the community. In addition to procedures for hospital staff, there are those which may be undertaken by other health service staff in the initial response to the death of a child.

Procedures detailed here relate to:

- The initial hospital response to the death of a child.
- Inter-agency liaison and planning.
- Agency notification and information gathering.
- Care of the child's family.
- History taking from the family.
- Examination of the child's body and obtaining early samples and x-rays.
- A joint agency visit to the home address or other place where the child died.

The management of the health service response to the death of a child must be undertaken by a senior children's professional. In the initial stages of the response that role will be undertaken by the on call Consultant Paediatrician (also referred to as the Acute Paediatrician) and/ or the child's / patient's named consultant for the relevant hospital and they will retain that responsibility until the case is handed over to the Rapid Response Nurse and Police.

The Designated Doctor for Sudden Unexpected Death in Infancy (SUDI), will have a clear role in supporting the Health service in delivering the response to a death of a child.

Notwithstanding the central role of the Rapid Response Team (Rapid Response Nurse and Police) each professional needs to know their role and the role of others in the investigation of the death and the provision of support to the family.

Initial Response

On arrival at the hospital the child should be taken to an appropriate area in the Accident and Emergency Department. Should the unexpected death of a child occur elsewhere in the hospital (children's ward or maternity unit or adult intensive care) these procedures should be followed at that location.

The family should be provided with privacy. A nurse should be allocated to look after the family and to keep them informed about what is happening. The nurse should record any medical or other information provided by the family.

The child should immediately be assessed and death confirmed or resuscitation started in accordance with hospital protocols. Unless it is clear that the baby has been dead for some

time (for example when rigor mortis or blood pooling are evident), resuscitation should always be initiated.

The parents should be given the option of being present during resuscitation. The allocated nurse should stay with them to explain what is happening.

The child's / patient named consultant and/ or on call Consultant Paediatrician should be immediately notified and will thereafter be responsible for management of the response to the child's death and ensuring that these procedures are followed until this is taken over by the Rapid Response Team.

Once the child's death has been confirmed the Police will be notified by telephone call to the Police Control Room. The member of staff calling should specify that the child death response procedures are being initiated and provide details of the child and circumstances. A Senior Police Officer will attend in response and will liaise with the acute clinician.

Once the fact of the child's death has been confirmed, any IV cannula, ET tube placement must be checked by an experienced doctor (e.g.: anaesthetist) not involved in the resuscitation before removing. This should be documented clearly in the medical notes. Accident and Emergency staff should follow local A+E protocol for SUDI or child death.

Any clothing removed and any items of clothing or bedding brought in with the child should be placed in labelled specimen bags. Where required these should be given to the Police Investigating Officer, although this is not routine. The clothing may assist the pathologist and occasionally be required for forensic examination. A record must be made of who removed the items and handed them to the Police. In certain circumstances clothing may not be returned to the parents until the Coroner or Police Investigating Officer agrees.

The child's / patient named consultant and/ or Acute Paediatrician will contact the Rapid Response team and agree an appropriate point for that clinician to assume responsibility for management of the case. The Police Investigating Officer will be informed of the decision reached.

The child's / patient named consultant and/ or Acute Paediatrician should refer the child death to the HM Coroner's office as soon as possible. The Hertfordshire Coroner's office number: 01707 292707. Notes should be securely emailed to the coroner's office once complete. coroner.service@hertfordshire.gov.uk

Nursing Staff should complete SUDI checklist according to local guidelines at West Hertfordshire Hospitals Trust (WHHT) or East & North Hertfordshire NHS Trust (E&N).

Inter-agency Liaison and Planning

The child's / patient named consultant and/ or Acute Paediatrician and the Police Investigating Officer will liaise at an early stage to:

- Share all currently available information on the death.
- Plan the urgent review of all records held at the hospital.
- Agree responsibility for notifying other agencies and professionals of the death and obtaining relevant information from their records. NB: This has been ratified by the Hospital Board and Caldicott Guardians.
- Plan initial actions to be undertaken jointly by health and Police professionals including:
    - Examination of the child's body, obtaining urgent post mortem samples and a skeletal survey.
    - Obtaining a full history from the family.

    - Formal identification of the child's body.
    - Provision of care and support to the family.
- Agree arrangements for liaison with the pathologist.
- Identify and coordinate any other actions required by the agencies own policies and protocols.
- Agree the point at which responsibility for multi-agency management of the case will be handed over to the Rapid Response Team to enable the planning of the home visit and further response to the death.

There should be a clear agreement in each case on specific roles and responsibilities.

The liaison process should be ongoing as new information is received.

All unexpected deaths should be referred to Children's Services as per local guidelines set out in the Hertfordshire Safeguarding Children Partnership procedures.

Any examination of the child's body, skeletal survey and taking of samples should be taken prior to the child being moved to the hospital where the forensic post mortem will take place. This may also affect the manner in which the history is obtained and may necessitate the child's / patient named consultant and/ or Acute Paediatrician carrying out some of the functions of the Rapid Response Nurse particularly in respect of briefing of the Pathologist. The child's / patient named consultant and/ or Acute Paediatrician will also examine the child's body and take necessary samples, if needed, by themselves without the presence of a police officer if the child's body is going to be imminently transferred to another hospital for post-mortem. Details of possible samples to be collected are listed below.

At the conclusion of their actions at the hospital the child's / patient named consultant and/ or Acute Paediatrician, Police Investigating Officer, Rapid Response Team and, if present, Social Worker should agree a record of what has been done, what actions are outstanding and who is responsible for their completion.

Agency Notification and Information Gathering

The sharing of information between agencies at an early stage following the report of a sudden unexpected child death is vital to the planning of the multi-agency response.

The following should be notified of the child's death, requested to check their records for relevant information relating to the child or other family members and to ensure that any appointments for the deceased child are cancelled:

- Designated Nurse for Safeguarding Children
- GP, Health Visitor, School nurse.
- Children Services team for the area where the child is normally resident or Emergency Duty Team out of hours.
- Other relevant health professionals involved in the previous care of the child.
- Police Child Abuse Investigation Unit (to include all Police databases).
- School, college, nursery or other provision attended by the child.
- CDOP Notification of Child Death Form (see Appendix 12) which should be completed online at https://www.ecdop.co.uk/Hertfordshire/Live/Public

- Where the child is normally resident outside of Hertfordshire the corresponding professionals in the home area should be notified and asked to check their records in addition to the Hertfordshire professionals.

All records held by the hospital in respect of the child and, where appropriate, any siblings should be obtained and reviewed by the child's / patient named consultant and/ or Acute Paediatrician. A copy of the patient's clinical records will be required by the pathologist and will accompany the deceased child to the mortuary. The original x-ray films, test results and any unexamined samples should also be provided to the Pathologist. These should be transferred in such a way that their evidential integrity is maintained.

Original records should be produced for retention by the hospital. Additional copies will be required by the Rapid Response Nurse, and sent via email to: hct.safeguardingchildren@nhs.net Copies of notes are not routinely given to police.

As a minimum any relevant information held by Children Services and the hospital should be obtained whilst the child and family are still at the hospital. The urgency with which checks of other records should be requested will be dependent upon the circumstances of the death. They should however be completed as far as is possible prior to the post mortem examination taking place.

Care of the Child's Family

When the child has been pronounced dead, the child's / patient named consultant and/ or Acute Consultant Paediatrician should break the news to the parents, having first reviewed all the available information. Always refer to the child by name. The interview should be in the privacy of an appropriate room. The allocated nurse should also be present. The family should be treated with respect and honesty. They should be allowed to ask questions at any stage. Unless there is an obvious cause of death, it is usually best to say that an opinion cannot be given at that stage.

Use the words Sudden Unexpected Death in Infancy (or Childhood). Explain there are a number of causes of sudden infant (or childhood) death including acute overwhelming infection and silent but severe congenital anomaly and the only way of finding out is by a process of systematic investigation. The same applies to children although less is known.

Parents should, in all but exceptional circumstances, be allowed to hold and spend time with their child. Professional presence should be discreet but vigilant during parents' time with their child.

Mementos should be offered routinely. If there are marks on the child's body which might be masked by taking mementos these areas must be avoided. Details must be recorded in the medical notes (e.g. lock of hair cut or palm or sole prints taken).If mementos are not taken in the Accident and Emergency Department, the local hospital bereavement office should be notified and a request made to arrange these after the post mortem examination.

Explain that samples will need to be taken in A&E according to protocol, as these may help identify a cause of death.

Unexpected child death referrals: Medical examiners and informing the Coroner

From October 2019, there is now a statutory requirement for medical practitioners to refer specific cases to the coroner in a specific written manner (see appendix 13), https://www.gov.uk/government/publications/notification-of-deaths-regulations-2019-

guidance and https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/831100/notification-deaths-regulations-2019-guidance.pdf).

Although a death of a person < 18 years of age is not, on its own, a statutory requirement; there are a number of statutory reasons why a coroner referral would need to be made. Furthermore, in most localities, coronial services would want to have cases of children dying less than 18 years be referred them for assessment.

It is a statutory requirement that the referral be made in writing.

Each of the acute Trusts should have a system (or be working towards developing a system) of Medical Examiners whose role it is to scrutinise deaths (including children < 18 years) occurring within the Acute Trust. The Medical Examiner's office and/ or the patient affairs office will be able to assist, the child's / patient named consultant and/ or Acute Consultant Paediatrician with the death review process, the referral to the coroner and completing the necessary statutory forms.

In the event that a unexpected child's death is not undertaken by the coroner's office for investigation or inquest, the Trust medical examiner will discuss the case with the child's / patient named consultant and/ or Acute Consultant Paediatrician and agree a cause (causes) of death in order to complete the Medical Certificate of Cause of Death (MCCD).

The family should be informed that the unexpected death will initially be notified to HM Coroner and that formal identification of the child's body to the Police and a post mortem examination may be required. If so, it should be sensitively explained to the family what this involves and that tissue samples will be taken for examination under the microscope. They should be told where this will be done and that if it is to be at a specialist centre, that the child will normally be returned to the hospital afterwards. They may be able to spend time with their baby before and after the post mortem examination in the hospitals chapel of rest.

The family should also be informed that to ensure that the investigation into the death of a child is as effective as possible and that the family are properly supported a number of agencies, including the Police, Health Service and Children's Services will be involved and will meet to plan any further actions that each will take. Details should be provided of any action planned, including any home visit to the home address and of the need to obtain a comprehensive history from the family. The involvement of agencies is routine, and does not assume suspicion.

It is important to ensure that someone is looking after any other young children in the family. 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. Other family members may wish to attend the hospital.

If the child is a twin, the other twin should be assessed immediately and admitted for a period of observation and investigation. It must be emphasised to the family that the admission of the surviving twin is because of the possibility of a natural medical condition that may have caused death in the other twin. If the family decline the offer of admission, this should prompt an urgent reconsideration of the family's needs and the health needs of the surviving twin. The health and safety of other siblings should also be considered.

Parents should be provided with relevant information for the hospital and agencies involved, including the Rapid Response Team, the Police Investigating Officer (or Family Liaison

Officer if appointed) and the Coroner's Officer. Supporting leaflets with contact details should be provided.

Before they leave the hospital the family should know where their child will be, and the contact details for the relevant co-ordinator whom they can contact if they wish to visit their child.

An offer should be made to inform the Foundation for the Study of Infant Deaths (FSID) who provide counselling for affected families and professionals. Any health staff involved in an unexpected child death can also contact the Lullaby Trust.

History taking from the Child's Family

The child's / patient named consultant and/ or Acute Paediatrician should take a detailed history from the parents / carers. The identity of the people present and their relationship to the child needs to be ascertained and detailed records made of who was present and what was said.

Unless there are indications that the death may be suspicious it will not be appropriate to separate the parents / carers to obtain the history from them, although note should be made of who provides the information. If the death is suspicious the Police Investigating Officer will take this into account when planning the taking of the history.

Take a routine medical history as far as possible, establishing place and circumstances of death. Appendix 8 provides a guide to areas which should be covered in the history taking. It cannot be regarded as comprehensive, as additional specific questions may arise as a consequence of information provided by the family. Some parts of the checklist are applicable to all children who have died. Others will be relevant only for children under the age of 2 and older children where there is no readily identifiable external cause of death or the child had a chronic medical condition or disability. If a death occurs during working hours a Rapid response nurse is likely to visit with the police. If a death occurs outside of working hours the history should be obtained with the medical team and the police together to reduce any distress to the parents. The full details of any history must be sent to the Rapid response team to avoid duplication.

Discretion is needed as to the amount of detail that should be sought in the first instance and the immediate history should be obtained first. If a visit to the home address is planned, a lot of the background information can be obtained from the medical records or during that visit. If, however, such a visit is not feasible, it will be necessary to collect as much information as possible whilst at the hospital.

Encouraging the parents to talk spontaneously with prompts about specific information is likely to be better than trying to collect a structured history. In recording the accounts of parents / carers it is important to use their own words as far as possible. Ideally, information should be recorded verbatim.

Much of the information is very sensitive. Parents may feel very vulnerable when asked about their sleeping arrangements, alcohol intake or drug use, so great skills is needed in asking the questions in a non-threatening way, with no implication of value judgement or criticism.

Examination of the Child's Body

Unless there are indications that the death is suspicious and an immediate forensic post mortem examination is to take place the child's / patient named consultant and/ or Acute Paediatrician should undertake a full general examination of the child's body. An adult

Consultant would be involved for children over 16 years and less than 18 years admitted to adult services areas within the hospital. Examination, under these conditions, should be done with the support of the paediatric team.

This examination should be ideally conducted with the Police Investigating Officer present.

Any marks and injuries should be documented on a body map. This should include the site and route of any intervention in resuscitation, for example, venepuncture or intra-osseous needle insertion.

The examination should include the genitalia for any signs of injury. Fundoscopy for retinal haemorrhage should be undertaken for all children under the age of 2 years. (Preferably by a Consultant Ophthalmologist, if the necessary expertise is available).This may take place the next day.

In cases that are complex and there are concerns about suspicion or injury, an ear temperature should be taken immediately on presentation, using a low reading thermometer if necessary. Care should be taken to examine the ear and record the findings before the temperature is taken.

Full growth measurements (length, weight and head circumference) should be taken and plotted on centile charts (where equipment is available). The child's general appearance, cleanliness and descriptions of any blood or secretions around nose or on clothes should also be noted.

Any visible marks and injuries should be photographed by a Police Forensic Investigator

(Scene of Crime Officer (SOCO).

In certain circumstances the child's body should not be washed or "cleaned up" as this may interfere with the pathologist's investigation. The child may be wrapped in a clean blanket. Where cleaning of the child's body is considered essential the Police Investigating Officer and child's / patient named consultant and/ or Acute Paediatrician must be consulted as it may be appropriate for the body to be photographed and / or swabbed before being cleaned.

Obtaining Samples

If any laboratory investigations were taken during resuscitation, these should be clearly documented.

Unless there are indications that the death is suspicious and an immediate forensic post mortem examination is to take place, samples for medical investigations should be taken routinely as soon as possible after death.

The recommended samples for children under 2 years are detailed below.

For older children the Paediatrician should consider which of the investigations are indicated on the basis of the medical history.

If there is definite external evidence of injury early samples should only be taken after discussion with the Police and Pathologist, as this could interfere with the interpretation of injuries at post mortem examination. However, the only opportunity to identify or exclude some medical conditions is by taking samples at or shortly after death and this should not be unnecessarily missed.

A contemporaneous and accurate record should be made of the site from which all samples are taken.

A chain of responsibility must be established for all samples taken and samples taken directly to the laboratory. The laboratory should be asked to store any samples that cannot be analysed straight away.

ROUTINE MINIMUM SAMPLES TO BE TAKEN IMMEDIATELY AFTER SUDDEN UNEXPECTED DEATHS IN INFANCY

Guidance and instructions for samples to be undertaken for unexpected deaths of children 0 – 18 years are clearly illustrated in East & North Herts and West Herts Hospital Trust organisational grab packs, as cited in Sudden unexpected death in infancy and childhood Multi-agency guidelines for care and investigation (2016).

The samples are highly recommended for children under 2 years. For older children the Paediatrician should consider which of the investigations are indicated on the basis of the medical history

Name of Child: **DOB:** **DOD:**

Name of Doctor: **Date samples taken:**

Table 2: Initial samples to be taken immediately after sudden unexpected death

Sample	Send To	Handling	Test
Blood (serum) 0.5 ml	Clinical chemistry	Normal	Urea and electrolytes
Blood (serum) 1 ml	Clinical chemistry	Spin, store serum at -20°C	Toxicology
Blood (lithium heparin) 1 ml	Clinical chemistry	Spin, store plasma at -20°C	Inherited metabolic diseases
Blood (fluoride) 1 ml	Clinical chemistry	Spin, store plasma at -20°C	3-OH butyrate, sugar, FFA, lactate
Blood EDTA 0.5 ml	Haematology	Normal	FBC
Blood cultures— aerobic and anaerobic 1 ml	Microbiology	If insufficient blood, aerobic only	Culture and sensitivity
Blood from syringe onto Guthrie card	Clinical chemistry	Normal (fill in card-do not put into plastic bag)	Inherited metabolic diseases
Blood (lithium heparin) 5 ml	Cytogenetics	Normal —keep un-separated	Chromosomes (if dysmorphic) (Post directly using standard protocol do not send to laboratory)
CSF (a few drops)	Microbiology	Normal	Microscopy, culture and sensitivity
CSF 0.5 ml	Clinical chemistry	Store at -20°C	Inherited metabolic diseases
Swabs from any identifiable lesions	Microbiology	Normal	Culture and sensitivity
1. Urine (if available)	Clinical chemistry	Spin, store supernatant -20*C	Toxicology, inherited metabolic diseases
2. Urine (few drops, if above sample taken)	Microbiology	Normal	Microscopy, culture and sensitivity
The above post mortem investigations are agreed with the Hertfordshire Coroner.			

CSF, cerebrospinal fluid EDTA, ethylene diamine tetra-acetic acid; FBC, full blood count; FFA, free fatty acid; OH, hydroxyl.

*Samples must be sent to an appropriate virological laboratory.

Tick which samples have been taken and record any needle sites on this form or on a body map, to aid the pathologist.

Skeletal Survey

Unless there are indications that the death is suspicious – and an immediate forensic post mortem examination is to take place – a full skeletal survey up to the age of 24 months (Sudden unexpected death in infancy and childhood Multi-agency guidelines for care and investigation, 2016, pp 36) should be performed. Children older than 24 months should be performed in conjunction with the designated paediatrician and by agreement with the Coroner and Police.. It should be reported before the post mortem examination by a consultant Radiologist experienced in interpreting paediatric X-rays. If the surveys have to be performed and reported out of hours, the X-rays should be reviewed by a specialist Paediatric Radiologist before the post mortem examination. In Watford General Hospital the skeletal survey will be done on the next working day.

The radiology must be a full skeletal survey not a 'babygram'. The British Society of Paediatric Radiology, have developed standards for skeletal surveys in suspected non-accidental injury (NAI) in children and these should be followed. These are included in Appendix 11.

Where there is a home office post-mortem being carried out then the pathologist should request the report from the on call consultant radiographer (via hospital switchboard)

CT Scans

There is no requirement to undertake a CT scan. However, from an investigative perspective, the police will want to collect as much evidence as possible depending on the facts of the case. Therefore the Senior Investigating Officer from Hertfordshire Constabulary in discussion with the child's / patient named consultant and/ or Acute Paediatrician would make this decision based on the needs of the investigation and in consultation with Coroner.

The Role of the Pathologist

The Pathologist will request all relevant reports prior to the post mortem via HM Coroner's Officer, these may include Medical, Police and reports from the Clinician who carried out the home visit /or took the family history. Where necessary the Pathologist can request a discussion with the Medical Case Clinician before and after the post mortem. This should be organised via HM Coroner's Officer.

Initial Post Mortem findings will be reported back to the Coroner's Officer.

APPENDIX 4 – HEALTH SERVICES / RAPID RESPONSE TEAM

The Rapid Response on call rota changed from 01/02/2018 to:
Monday – Friday: 08.00 – 17.00 hours
Weekends and Bank-holidays: 08.00 – 12 mid-day.

Should any deaths occur outside the duty rota time, a verbal message and contact details should be left on the Rapid Response contact number voice-mail (no text messages) and the Rapid Response nurse on call will respond to your call at 08.00 hours the following day to discuss and progress the Rapid Response process.

The Rapid Response Nurse will be notified by the child's / patient named consultant and/ or Acute Paediatrician/Senior Nurse/Police of the death of a child in hospital or who has been brought to an Accident and Emergency Department having died in the community.

The Rapid Response Nurse will thereafter have responsibility for ensuring that the health service response to the death is in accordance with these procedures and should agree with the child's / patient named consultant and/ or Acute Paediatrician the point at which he/she will take over that role the operational management of the response. In most circumstances this will be when the initial response at the hospital is completed.

The Rapid Response Nurse will also be notified by the Police Investigating Officer if in exceptional circumstances the body of a child who has died has not been removed to hospital and by the Coroner's Officer if the body of a child has been conveyed directly to the mortuary. In such cases the lead Paediatrician will liaise with the Police Investigating Officer to coordinate a subsequent response which complies with these procedures as closely as possible.

The Rapid Response Nurse will conduct the joint visit to the home address (or to the place where the child collapsed / died, if different) if appropriate or deemed necessary with the Police Investigating Officer.

The Rapid Response Nurse will discuss and agree with the police officer the management of the question and answers session and home visit.

Notes made from the interview led by the Rapid Response Nurse must be contemporaneous and verbatim to ensure that they meet the needs of the court at future dates.

The Rapid Response Nurse will obtain from the child's / patient named consultant and/ or Acute Paediatrician a full report on the initial response to the child's death. This should include details of any outstanding actions and the Rapid Response Nurse should, in conjunction with the Police Investigating Officer, arrange for these to be completed.

The Rapid Response Nurse will also, at the earliest opportunity, obtain and review all medical records relating to the child.

The Paediatrician should provide the Pathologist with all medical records relating to the child and details of any x-rays and tests carried out. The original x-ray films, test results and any unexamined samples should also be provided to the Pathologist. These should be transferred in such a way that their evidential integrity is maintained.

Copies of the original records should be retained by the Rapid Response Nurse to facilitate management of the investigation and review process and provided to the original record holder and the Police Investigating Officer.

The Rapid Response Nurse will, in conjunction with the Police Investigating Officer, fully brief the Pathologist and should include all information obtained during the initial

investigation, a full medical report based on the history given by the parents in hospital, examination of the child immediately after death, information obtained during the home visit and examination of all relevant medical and social records. In very young babies this might include obstetric records. Any photography of the scene or of the child at presentation or in the Accident and Emergency Department should be provided to the Pathologist prior to starting the post mortem. This should be submitted as formal report to the Coroner.

Inadequate briefing may result in failure to carry out the tests that might lead to the identification of a cause of death.

The Rapid Response Nurse may attend the post mortem examination. Where this does not occur the Coroner's Officer can request that there be adequate discussion between the Rapid Response Nurse and the Pathologist both before and after the post mortem examination. Thereafter the Rapid Response Nurse will ensure that the Administrator is aware of the child's death and is responsible for managing the multi-agency planning and review arrangements.

The interim findings of the post mortem examination should be provided in writing by the pathologist to HM Coroner, the Police Investigating Officer and the Rapid Response Nurse immediately after the post mortem examination is completed.

The final report on the post mortem examination should be similarly provided to HM Coroner, the Police Investigating Officer and the Rapid Response Nurse. .

Home Visit

Joint visit to the home address (or to the place where the child collapsed / died if different) by the Rapid Response Nurse and the Police Investigating Officer: unless there are compelling reasons to the contrary a home visit will be carried out.

Where the death is considered suspicious the arrangements for the visit will be considered by the Police in the context of the overall investigation and particularly the forensic strategy for the scene.

Such visits should take place as soon as possible and in any case within 24 hours of the death. Arrangements should be made to ensure that the scene of the child's collapse and / or death is left undisturbed until the visit takes place. At the discretion of the Police Investigating Officer, the Police may have visited the scene of death immediately and be maintaining a presence there. Police will be asked not to remove the child's bedding prior to the Rapid Response Nurse visiting the home except in exceptional circumstances which should be recorded.

If a joint visit is impossible within this time frame, separate visits should occur. If separate visits are arranged, then the Response Nurse and the Police Investigating Officer should confer soon afterwards to share their findings and discuss their interpretation.

It must be explained to the family that this is a routine part of the investigation to help identify and understand the factors that have contributed to the death and provide information for the pathologist, prior to the post mortem examination.

The purpose of the visit is to:

- Explore the circumstances of the death, relevant events and previous history, filling any gaps in and supplementing the information which was obtained at the hospital or from agency records.
- Carry out a systematic examination of the site of the child's death.

- Ensure that the family are fully informed about the multi-agency approach to the death of the child and the support available to them.

The Police Investigating Officer will arrange for the scene to be photographed by a Police Forensic Examiner. This should normally take place towards the end of the home visit when the Police Investigating Officer is in a position to set parameters for the Forensic Investigator.

There may also be a need to remove items from the scene. This will be undertaken by the Police Forensic Investigator and the decision to take items will be made by the Police Investigating Officer in conjunction with the Rapid Response Nurse.

The home interview and visit to the place where the child died can be very difficult, but may also be of great value in understanding the sequence of events leading to the death. Parents commonly find this home interview, whilst stressful and sometimes painful, very helpful. The fact that the Rapid Response Nurse is willing to spend this time with them, helping to understand what has happened to their child may in itself be very important to the family.

At the end of the interview, it is essential that the Rapid Response Nurse spends some time with the family ensuring they know that will happen next, when they will next be contacted by the Rapid Response Nurse, when and where the post mortem will take place, and how they will be informed of the preliminary results.

Time will also be needed for the Rapid Response Nurse to help the parents deal with the very powerful emotions that are commonly brought out by this discussion.

NB:
The Rapid Response process may need to commence the following day due to rota changes.

APPENDIX 5 - POLICE

Introduction

This section should be read in conjunction with the General Guidance and applied in the context of the procedures applicable to other agencies.

Responsibilities;

- To investigate the circumstances of the death on behalf of HM Coroner.
- To establish if a crime has been committed and if so, to investigate that crime.
- To participate in the LSCB response to the death as described in these procedures including contributing to any action required to protect other children in the family from any identified child protection risks.

Procedures detailed here relate to:

- Investigative Responsibility.
- Reporting the death to HM Coroner.
- Receipt of call and deployment.
- Child deaths at hospitals outside of Hertfordshire.
- Initial attendance.
- Rapid Response (RR) Protocols
- Agency notification and information gathering.
- Care of the child's family.
- History taking from the child's family.
- Examination of the child's body and obtaining samples and x-rays.
- Identification.
- Home visit.
- Multi-agency arrangements.

These should be followed in conjunction with and additional to any other procedures applicable to the circumstances of the death (e.g. ACPO Murder Investigation Manual).

Rapid Response Protocols

- Police will contact RR Nurse
- Police will allocate a Family Liaison Officer (FLO)
- Both will meet either at hospital or home address
- Scene visit alongside Scene Of Crime Officer (SOCO)
- Police and RR Nurse to conduct Question & Answers (History taking) and identification of child with family.
- RR Nurse will arrange the professionals meeting within 5 working days.
- FLO will complete file for coroner

- Referrals to partner agencies will be completed by JCPIT.

Investigative Responsibility

Lead responsibility for the investigation of the sudden or unexpected death of a child will be the undertaken by:

- If at the outset or subsequently there any indications that the death of a child is suspicious, a Senior Investigating Officer from the Bedfordshire, Cambridgeshire Hertfordshire Major Crime Unit (BCH MCU)
- If the death appears to be a Sudden Unexpected Death in Infancy (SUDI), a Senior Investigating Officer from the Joint Child Protection Investigation Team (JCPIT) (a SUDI is a death of a child under the age of two years)
- If the death results from a Road Traffic Collision, a Road Policing Unit Investigator.
- In all other cases, a Detective Inspector from JCPIT will be the Senior Investigating Officer

In all cases of child death a referral will be made into the Joint Child Protection Investigation Team.

If at any point in the investigation there are indications that the death is suspicious the BCH MCU Senior Investigating Officer will be contacted and will assume lead responsibility for the investigation.

Receipt of Call and Deployment

The Force Communications Room (FCR) will be responsible for the initial deployment of resources.

FCR will contact Ambulance Service immediately if not already notified and enroute.

If the death is a result of a road traffic collision (RTC), initial deployment will be Road Policing Unit (RPU) as per Standard Operating Procedures (SOP). JCPIT will be notified.

JCPIT will initiate Rapid Response Protocol on notification of death.

Child Deaths at Hospitals Outside of Hertfordshire

If, following an incident in Hertfordshire, the child has been taken to a hospital outside of Hertfordshire, the relevant Police force will be contacted and requested to initiate their LSCB procedures for an initial response to the death of a child at the hospital.

In these circumstances the JCPIT Supervisor will be responsible for:

- Liaison with Police force and other agencies where the hospital is located to ensure a coordinated initial response.
- Notify as soon as possible the RR Nurse, share the circumstances of the death and agree an action plan.

Initial Attendance

First officer on scene may be expected to commence CPR until other professionals arrive.

Initial officers, after Ambo/Paramedics have taken over the care of the child, shall preserve the scene and commence a scene log.

Officers should note the position, location, clothing worn by the child and any comments made by carers or others at the scene. Background history and living conditions will be covered under the RR Protocol.

The child should be removed to the Accident and Emergency Department by Ambulance, if death is pronounced at the scene and there are no suspicious circumstances, the carers may under discreet observation hold their child. Officers will always accompany the child to hospital.

Officers will be required to preserve evidence and seize items such as;

- Last feed
- Nappy worn
- Any significant item such as baby nests
- Only in exceptional circumstances would there be a need to seize medical items or secure and ambulance or hospital room

Body Worn Video (BWV)

Officers will record their immediate response, including the scene where any such incident has occurred. Officers MUST NOT however record any medical professional carrying out their duties.

If an officers needs to attend a hospital NO treatment should be recorded on the BWV. This does NOT negate the necessity to record criminal activity within the same arena. On every occasion the officer must be sensitive to the nature of their surroundings before making the decision to record on hospital premises.

Care of the Child's Family

Initial care of the family will normally be undertaken by hospital staff. The Police should however assist with this wherever possible and where a Family Liaison Officer has been appointed it will normally be appropriate for that officer to work closely with the relevant health service professional.

Parents should, in all but exceptional circumstances, be allowed to hold and spend time with their child. Professional presence should be discreet but vigilant during parents' time with their child.

Mementos should be offered routinely. If mementos are not taken in the Accident and Emergency Department the Coroner's Officer should be notified and a request made to arrange these after the post mortem examination.

The family should be informed that the death must be notified to HM Coroner and that formal identification of the child's body to the Police and a post mortem examination will be required. It should be sensitively explained to the family what this involves and that tissue

samples will be taken for examination under the microscope. The family should be informed where this will be done and that if it is to be at a specialist centre, that the child will normally be returned to the hospital afterwards. They will usually be able to spend time with their child after the post mortem examination.

The family should also be informed that to ensure that the investigation into the death of a child is as effective as possible and that the family are properly supported a number of agencies, including the Police, Health Service and Children Social Care will be involved and will meet to plan any further actions that each will take. Details should be provided of any action planned, including any visit to the home address and of the need to obtain a comprehensive history from the family.

It is important to ensure that someone is looking after any other young children in the family. 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.

Before they leave the hospital the family should know where their child will be, and the contact details for the relevant co-ordinator whom they can contact if they wish to visit their child.

They should also be provided with contact details for the Case Clinician, the Police Investigating Officer (or Family Liaison Officer if appointed) and the Coroner's Officer.

History taking from the Child's Family

Often medical staff interview parents before the police arrive at hospital in an effort to establish the circumstances surrounding the child's collapse. This account should be obtained by the Police Investigating Officer and the RR Nurse.

The RR will undertake the Q&A with Police Officer present when the death is not deemed suspicious.

A record of all those present and their relationships should be taken

Unless there are indications that the death may be suspicious it will not be appropriate to separate the parents / carers to obtain the history from them, although note should be made of who provides the information. If the death is suspicious the Police Investigating Officer will decide whether any interviews with the parents / carers need to be carried out under the Police and Criminal Evidence Act, 1984 and how this may fit into the overall investigation plan.

Ideally, information should be recorded verbatim. Much of the information is very sensitive. Parents may feel very vulnerable when asked about their sleeping arrangements, alcohol intake or drug use, so great skills is needed in asking the questions in a non-threatening way, with no implication of value judgement or criticism.

Examination of the Child's Body Examination and Obtaining Samples and X-rays

Unless there are indications that the death is suspicious and an immediate forensic post mortem examination is to take place the child's / patient named consultant and/ or Acute Paediatrician should undertake a full general examination of the child's body. An adult Consultant would be involved for children over 16 years and less than 18 years admitted to adult services areas within the hospital.

The Police Investigating Officer should be present when this is conducted and ensure that all marks and injuries are recorded along with the child's / patient named consultant and/ or Acute Paediatricians opinion on their cause.

The child's general appearance, cleanliness and descriptions of any blood or secretions around nose or on clothes should also be noted. The child's body should not be washed or "cleaned up" as this may interfere with the pathologist's investigation.

Any visible marks and injuries should be photographed by a Police Forensic Investigator.

Any clothing removed should be appropriately packaged and retained by the Police. Care should be taken to ensure the evidential integrity and continuity of all exhibits and samples, including any taken during attempts at resuscitation, and the Police Investigating Officer or Forensic Investigator should advise hospital staff on these issues.

Identification

The Police Investigating Officer should ensure that wherever possible the child body is formally identified at the hospital, or at least prior to the post mortem examination taking place, and that continuity of identification is maintained through to the post mortem examination.

At each stage in the chain of continuity, appropriate witness statements must be obtained.

Home Visit

A visit to the home address (or to the place where the child collapsed / died if different) by the RR Nurse and the Police Investigating Officer will be carried out unless there are compelling reasons to the contrary.

Such visits should take place as soon as possible and in any case within 24 hours of the death. Arrangements should be made to ensure that the scene of the child's collapse and / or death is preserved until the visit takes place and this may, at the discretion of the Police Investigating Officer, involve maintaining a Police presence there.

If a joint visit is impossible within this time frame, separate visits should occur. If separate visits are arranged, then the case clinician and the police officer will confer soon afterwards to share their findings and discuss their interpretation.

It must be explained to parents that this is a routine part of the investigation to help identify and understand the factors that have contributed to the death and provide information for the pathologist, prior to the post mortem examination.

The purpose of the visit is to:

- Explore the circumstances of the death, relevant events and previous history, filling any gaps in and supplementing the information which was obtained at the hospital or from agency records.
- Carry out a systematic examination of the site of the child's death.
- Ensure that the family are fully informed about the multi-agency approach to the death of the child and the support available to them.

Where the death is considered suspicious the arrangements for the visit will be considered by the Police in the context of the overall investigation and particularly the forensic strategy for the scene.

The Police Investigating Officer will arrange for the scene to be photographed by a Forensic Examiner. This should normally take place towards the end of the home visit when the Police Investigating Officer is in a position to set parameters for the Forensic Investigator.

There may also be a need to remove items from the scene. This will be undertaken by the Police Forensic Investigator and the decision to take items will be made by the Police Investigating Officer in conjunction with the Responsible Paediatrician.

Bedding will only be taken if there are obvious signs of forensic value such as blood, vomit or other residues. The routine collection of bedding is neither necessary for any investigative purpose, nor appropriate for the family. Items such as the child's used bottles, cups, food or medication together with any used nappies will normally be taken. There is no need to retain any other clothing unless the child's clothes have been changed prior to the arrival of the police.

If any medical equipment has been used for the child (e.g. syringe drivers, portable ventilators) these should be taken after advice is obtained on how to preserve any internal records settings.

If it is necessary to remove items from the house, this should be done with consideration for the parents. It should be explained that this may help to find out why their child has died. Parents / carers should be asked if they want the items returned.

At the earliest opportunity after the investigation is completed, any items the family wish to have returned, should be returned to them. All police documentation will be removed and the property will be returned if appropriate in new/clean wrapping/bags. If soiled articles were taken, parents/carers should be asked about their return, and if they would like them cleaned prior to return. An appointment should be made with the parents/carers to return any property, remembering that this could be a significant event for them

Reporting the Death to HM Coroner

In all cases the Coroner's Officer must be notified of the death as soon as possible in accordance with statutory requirements of medical practitioners and police. On referral, the Coroner should be provided with full details, in a written format, of the circumstances of the death and any special considerations relative to the post mortem examination in order that HM Coroner can be briefed and appropriate arrangements can be made. The medical examiner's or patient affairs office will be able to assist in this regard.

The statements relating to identification of the child's body should be forwarded to the Coroner's Officer as soon as possible to enable an Inquest to be opened.

The Police Investigating Officer and the Coroner's Officer should continue close liaison throughout the investigation.

Post Mortem Examination

The Police Investigating Officer, in conjunction with the child's / patient named consultant and/ or Acute Paediatrician should ensure that the Pathologist is provided with full details of the circumstances. including all information obtained by their initial investigation, a full medical report based on the history given by the parents in hospital, examination of the child immediately after death, information obtained during the home visit and examination of all relevant medical and social records. In very young babies this might include obstetric records. Any photography of the scene or of the child at presentation or in the Accident and Emergency Department should be provided to the Pathologist prior to starting the post mortem. Inadequate briefing may result in failure to carry out the tests that might lead to the identification of a cause of death.

The Police Investigating Officer should if necessary attend the post mortem examination. If this is not possible, then they must send a representative who is aware of all the facts of the case. A Forensic Investigator must attend all post mortem examinations conducted by a Home Office pathologist.

Multi-agency Arrangements

The Joint Child Protection Investigation Team Supervisor and, if different, the Lead Investigator should attend the multi-agency Information Sharing and Planning Discussion and Case Review Meeting.

The Police Investigating Officer will notify the Administrator of the child's death.

APPENDIX 6 - SOCIAL CARE

This section should be read in conjunction with the General Guidance above and applied in the context of the procedures applicable to other agencies.

Children Social Care or Hertfordshire County Council Customer Service Centre may hold information in respect of a child who has died or their family. Customer Service Centre or the Safeguarding Out of Hours Service will be contacted by either the Police or the child's / patient named consultant and/ or Acute Paediatrician as part of the initial information gathering procedure and should share any information held.

Children Social Care may become more directly involved in the initial response to the death of a child either where there are specific support needs of the family, especially if there are other children, or where there are child protection concerns arising from the circumstances of the death.

Any child protection concerns will be addressed in accordance with HSCP procedures and Social Care has lead responsibility for these issues. If any action is considered necessary in advance of the multi-agency Information Sharing and Planning Discussion the Social Worker should coordinate this with the Health and Police professionals responding to the child death. In all but exceptional circumstances this should be through convening a formal child protection strategy meeting.

A Children Social Care representative will always be invited to the multi-agency Information Sharing and Planning Discussion and Case Review Meeting.

APPENDIX 7 - CORONER'S OFFICER AND PATHOLOGIST

This section should be read in conjunction with the General Guidance above and applied in the context of the procedures applicable to other agencies.

Any child whose death is sudden or unexpected should be taken to the Accident and Emergency Department. If, for any reason, a child's body is taken directly to the mortuary, the mortuary team or Coroner's Officer (if notified) will immediately inform the duty Child Abuse Investigation Unit Supervisor. Those professionals will thereafter coordinate subsequent action which complies with these procedures.

The Coroner's Officer will be notified of a child's death in accordance with existing Police policies by the Police Investigating Officer.

The Coroner's Officer is thereafter responsible, on behalf of HM Coroner for:

- Arranging for a post mortem examination.
- Informing all relevant professionals of the time and place of the post mortem examination, including the Police Investigating Officer and the Rapid Response Nurse.
- Informing the family of the time and place of the post mortem examination.
- Liaising with the family about mementos if these have not been taken in the Accident and Emergency Department.
- Liaising with family regarding retention of tissue and organs and obtaining necessary signatures.
- Ensuring, in liaison with the Rapid Response Nurse, that all medical records, x-rays and test results are forwarded to the paediatric Pathologist prior to the post mortem examination.
- When interim and final post mortem reports are received from the Pathologist, forwarding copies of these to the Rapid Response Nurse Coordinator via the admin team, Police Investigating Officer and GP.
- Ensuring effective communication between those professionals involved in the multi-agency response to the child's death and HM Coroner.
- Ensuring that the family's wishes regarding disposal of any body tissues retained from the post mortem examination are made known to the Pathologist and HM Coroner.
- Ensuring that the child's body is released for burial or cremation as soon as possible.

Where a Police Family Liaison Officer has been appointed it may be appropriate for some of these responsibilities to be undertaken by that Officer

If possible the post mortem examination should be completed within 48 hours of the child's death.

In all cases, the post mortem examination should be carried out by a Paediatric Pathologist.

If there are any concerns that the death may be suspicious nature, a Home Office Pathologist will be used in conjunction with a paediatric Pathologist. Where a Pathologist is qualified both as a forensic and paediatric Pathologist they may complete the post mortem examination on their own.

If during the post mortem examination a Pathologist becomes at all concerned that there may be suspicious circumstances, they must halt the post-mortem and inform the Coroner's Officer and Police Investigating Officer.

The pathologist must be provided with full details of the circumstances. This briefing is best done by the child's / patient named consultant and/ or Acute Paediatrician, in conjunction with the Police Investigating Officer, and should include all information obtained by their initial investigation, a full medical report based on the history given by the parents in hospital, examination of the child immediately after death, information obtained during the home visit and examination of all relevant medical and social records. In very young babies this might include obstetric records. Any photography of the scene or of the child at presentation or in the Accident and Emergency Department should be provided to the Pathologist prior to starting the post mortem.

Inadequate briefing may result in failure to carry out the tests that might lead to the identification of a cause of death.

The child's / patient named consultant and/ or Acute Paediatrician should also provide the Pathologist with all medical records relating to the child and details of any x-rays and tests carried out. The original x-ray films, test results and any unexamined samples should be provided to the Pathologist. These should be transferred in such a way that their evidential integrity is maintained.

All documents to be forwarded should be copied and the copies retained in place of the originals. Additional copies should be made for the Rapid Response Nurse to facilitate management of the investigation and review process and for the Police Investigating Officer.

The Police Investigating Officer should attend the post mortem. If this is not possible, then they must send a representative who is aware of all the facts of the case. A Forensic Investigator must attend all post mortem examinations conducted by a Home Office pathologist. The Rapid Response may also attend. Where this does not occur there must be adequate discussion between the Rapid Response Nurse and the Pathologist both before and after the post mortem examination.

The interim findings of the post mortem examination should be provided in writing by the pathologist to HM Coroner, the Police Investigating Officer and the Rapid Response Nurse immediately after the post mortem examination is completed.

The final report on the post mortem examination should be similarly provided to Coroner, the Police Investigating Officer and the Rapid Response Nurse.

The Rapid Response Nurse, through the Corner's Officer, will ensure that HM Coroner is made aware of any information arising from the multi-agency Information Sharing and Planning Meeting or Case Review Meeting which may impact on HM Coroner's view determination of cause of death and whether an inquest should be held.

Notwithstanding the above, if the death is from natural causes, HM Coroner will notify the Registrar as to the medical cause of death to enable the death to be registered and a death certificate issued. If the death is not 'natural', this notification to the Registrar may be delayed pending the outcome of criminal proceedings or an inquest.

HM Coroner, the Pathologist and the Coroner's Officer will always be invited to the multi-agency Information Sharing and Planning Discussion and Case Review Meeting

APPENDIX 8 – INFORMATION TO BE COLLECTED AT THE FIRST INTERVIEW AND THE HOME VISIT

Introduction

The importance of the history being taken by an experienced professional, with knowledge and understanding of the care of children and sensitivity to the needs of the family, cannot be over-emphasised.

This list is meant as a guide. It cannot be comprehensive, as additional specific questions may arise as a consequence of information given by the parents.

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

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

The Child

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

Mother

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

Mother's Partner and/or Father of Child

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

Other Members of the Household (Present and in the Recent Past)

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

Family Medical History

- A detailed account of past medical and social history of all members of immediate family and household.
- Particular note and detailed information (name, date of birth, place of birth) of any previous children.
- Also detailed information on any deaths in infancy or childhood of any offspring, siblings or other close relatives of any member of the current household (to include as much information as possible concerning date of birth, age at death, place of death, cause of death and any other known information).

Social and Family History

- A detailed account of the social structure of the family and of the household, including detailed information on alcohol, tobacco and other drug use, together with information on any prescription or non-prescription medications that may have been present or in use in the household.
- Information on recent changes in composition of the household (e.g. who has come and who has gone, and for what reasons).

Detailed Medical History of Mother

- Details of past medical and social history of the mother, including any significant past illnesses or injuries.
- Detailed past obstetric history, including detailed information on the pregnancy leading to the birth of the child who has died.

Detailed Medical and Developmental History of the Child who has Died

To include:

- Gestation
- Birth weight
- Perinatal or neonatal problems
- Type of feeding (and date and reason for changing type of feeding)
- Growth, development and past assessments (e.g. Health Visitor or GP routine, well-child checks)
- Immunisations
- Any known contact with infection
- Medication (either prescribed or over the counter)
- If possible, obtain the parent-held child health record to copy (return this to the parents after copying it); plot the weight record onto a centile chart.

A detailed narrative account of the child's feeding, sleeping, activity and health over the two-week period prior to the death

This should include information on:

- Changes in feeding or sleeping patterns
- Changes in place of sleep
- Any social, family or health related changes in routine practices over the past two weeks
- Any illness, accident or other major event affecting other family members in the past two weeks.

A detailed (hour-by-hour) narrative account of events within the 48 hours prior to the child being found dead

A detailed description of:

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

The Final Sleep

A very careful description of when and where the child was placed to sleep, including:

- The nature of the surface
- Clothing
- Bedding
- Arrangement of bedding
- Precise sleeping position
- Who was sharing the surface on which child was sleeping (e.g. bed or sofa)
- How often the child was checked
- When he or she was seen or heard
- The times at which the child awoke for feeds
- Whether feeds were given
- Whether they were taken well
- Who else was in the room at each stage
- What were the activities of others in the room
- Were they awake
- Where, when and by whom was the child found
- What was the appearance of the child when found
- What was the position of the child when found
- Where was the bedding
- Were there any covers over the child
- Had the covers and the position of the covers moved
- Were there other objects in the cot or bed adjacent or close to the child (e.g. teddies, dolls, pillows)
- Was the heating on
- What type of heating was there
- Were the windows and/or doors open?

Action after Child was found

A detailed narrative account of events that followed the discovery of the child collapsed or apparently dead, to include details of:

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

Further Specific Questions

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

- Whether the child was feeding as well as, or less well than, usual in the past 24–48 hours
- Any vomiting
- Any respiratory difficulty, noisy breathing, in-drawing of the ribs, wheezing or stridor
- Excessive sweating
- Unusual activity
- Unusual behaviour
- Level of alertness
- Difficulty sleeping
- Difficulty waking the child
- Passage of stool and urine (how often and how much)
- Were any healthcare professionals consulted within the past two weeks, the past 48 hours or the past 24 hours
- If so, who was contacted, what was the problem described to the healthcare professionals and what advice was given
- Was the child seen and assessed by any healthcare professional during the past two weeks?

Whilst most of the medical and social history will be obtained during the initial discussion with the parents in the Emergency (A&E) Department, a very careful and detailed account of the final 24–48 hours will almost always be considerably supplemented by information collected at the time of the initial home visit and close examination of the circumstances of death. A written statement should be completed and sent to the Coroner.

The home interview and visit to the place where the child died can be very difficult, but may also be of great value in understanding the sequence of events leading to the death. Parents commonly find this home interview, whilst stressful and sometimes painful, very helpful – the fact that the Paediatrician is willing to spend this time with them, helping to understand what has happened to their child may in itself be very important to the family and many questions commonly arise out of this visit (in particularly in relation to the factors that may have contributed to the death).

At the end of the interview, it is essential that the Paediatrician spends some time with the family ensuring they know what will happen next, when they will next be contacted by the Paediatrician, when and where the post-mortem will take place, and how they will be informed of the preliminary results.

Time will also be needed for the Paediatrician to help the parents deal with the very powerful emotions that are commonly brought out by this discussion. If conducted sensitively and with awareness of the parents' needs, this interview can have a therapeutic 'debriefing' value for the family – commonly allowing them to talk about some of their feelings for the first time. Parents have commonly reported that this home visit has been an extremely important and very positive aspect of their care.

APPENDIX 9. PROFORMA (this is an example, there is a separate proforma for an infant and child and are available from the Rapid Response Lead)

SUDI HOME VISIT

Nursing Rapid Response report

Baby's Name:	GP:
	HV:
DOB:	Nursery / Child Minder:
Tel No:	
NHS No:	

Mother's Details:
Address: Post Code:
Tel No:

Mother's Partner:
Address: Post Code:
Tel No:

Baby's Father:
Address: Post Code:
Tel No:

Social Worker: Base: Tel No:

Rapid Response Record

Police Officer:

Base:

Tel No:

Name(s) of Visiting Nurse(s):

Name(s) Hospital Based Doctor(s) Involved:

Is the baby subject to a Child Protection Plan? Yes / No
Is the baby subject to a Child in Need Plan? Yes / No
Is there any identified vulnerabilities for the child or within household? Yes / No
Is their known Domestic Abuse in the Household? Yes / No
Has the child been diagnosed with any special needs or learning disabilities? Yes / No Please list:

Visit Details:

Date & Time of Visit Request:

Date & Time Visit Commenced:

Information from Police

Information from Hospital

Date & Time of Arrival:

Time of Death:

Medical History:

Person(s) Supplying History at Time of examination:

Others Present:

Birth History:	
Place of Birth:	Neonatal Unit:
Pregnancy:	Early Bonding:
Gestation:	Crying/Feeding Problems:
Birth Weight:	

Immunisations:

Development:

Smiled:

Sat:

Reached Out:

Babbled:

Family History:

Draw a Family Tree:

Is there any relevant family history?

*Place * by members of the household*

Full Details of Other Children:

DOB:	Name:	Health: (including immunisation history)
DOB:	Name:	Health: (including immunisation history)
DOB:	Name:	Health: (including immunisation history)
DOB:	Name:	Health: (including immunisation history)

Full Details of Parent's Health:

Mother DOB:	Past Health (*inc*. mental health): Past Obstetric history:	Smoke: Drink: Medications: Recreational Drugs Occupation:

Father or Partner: DOB:	Past Health (*inc.* mental health):	Smoke: Drink: Medications: Recreational Drugs: Occupation:

Other Relevant Family / Household Members	Who: DOB: Health:	Smoke: Drink: Medications: Recreational Drugs: Occupation:

Full Details of Baby:

Medical History

Illnesses:

Feeding History

Weight from PHR

Baby's health previous 2 weeks

Events 48 hours before death: *Place of sleep, duration sleep, position at end of sleep, changes in routine, alcohol, recreational drug*

Full Details of Baby:

Final sleep: *Nature of surface, clothing, bedding, sleeping position, who with, last seen, time of feeds & waking, others in room, who found baby, where was the bedding, any covers over baby, other objects in bed, heating details, door windows open?*

Action when baby found: *Who found baby, when 999, resuscitation attempt, responses, how long did ambulance take?*

Specific questions: *Was baby well last few hours, vomiting, breathing problem, sweating, alertness, irritability, stool, urine, doctor consulted?*

Details of House:

Kitchen: *Comments on any matters of concern:*

Living areas: *Comments on any matters of concern*:

Bedroom and bedding: *Comments on any matters of concern:*

Other: *Comments on any matters of concern*:

Completion of visit at:
Signature:

APPENDIX 10- Support Links

Foundation for SIDS – The Lullaby Trust

APPENDIX 11 - SKELETAL SURVEY

According to the Sudden unexpected death in infancy and childhood: Multi-agency guidelines for care and investigation (2nd edition, November 2016), it is deemed best practice that a skeletal survey is undertaken in the local (host) hospital prior to transfer for post mortem, to identify possible abnormalities as soon as possible. The findings will inform the tertiary hospital where a second skeletal survey takes place. According to the guidance, all children under 24 months who die should have a full radiological skeletal survey.

The Multi-agency guideline states that:

"The lead health professional should arrange for a full radiological skeletal survey or other appropriate imaging to be undertaken. This may be undertaken at the local hospital prior to transfer of the infant for post-mortem examination. It should be performed and reported by an experienced paediatric radiologist prior to the post-mortem examination being commenced. For children over 24 months, the need for such imaging should be discussed with the designated paediatrician. Imaging investigations should be reported on as soon as possible in order to identify or rule out bony injuries, as this may change the focus of the investigation."

APPENDIX 12. CORE DATA SETS/E-CDOP.

There are many different core data sets that may be required to be completed and the form depends on the circumstances to the death. When there is a requirement for one of the specific forms to be completed, an e-mail from E-CDOP will be sent to the practitioner within the different organisations.

Notification of the death of an infant can be done at https://www.ecdop.co.uk/Hertfordshire/Live/Public

APPENDIX 13. Notification of deaths Regulations 2019: Guidance on reporting a death to the coroner.

The notification requirement:

1. A registered medical practitioner means a person on the General Medical Council's list of Registered Medical Practitioners, who has a licence to practice.

2. It is anticipated that in practice, where available, it will be one of the attending medical practitioners who is qualified to complete the medical certificate cause of death (MCCD) who will be making the notification to the senior coroner.

3. If you have questions about the cause of death, or about completing the MCCD, you should discuss these with a medical examiner where one is available.

4. A death may have already been reported to the coroner by a person other than a medical practitioner, such as a friend or family member of the deceased, or the police. Such reports will not usually include the information required at regulation 4(3) and (4), and may not provide the coroner with the full medical picture.

5. Therefore, even if a medical practitioner is aware that someone other than a medical practitioner has reported a death to the coroner, the registered medical practitioner should still make a notification under the Regulations.

Circumstances in which a notification should be made under regulation 3

6. A death under the circumstances set out as follows should always be notified, regardless of how much time has passed since the death.

7. A death must be notified to the relevant senior coroner where there is reasonable cause to suspect that the death was due to (that is, more than minimally, negligibly or trivially), caused, or contributed to by the following circumstances:

The death was due to poisoning including by an otherwise benign substance

8. This applies to deaths due to the deliberate or accidental intake of poison, including any substance that would otherwise be benign, beneficial or tolerable but at certain levels is injurious to health, such as sodium (salt).

9. In regard to alcohol or smoking related deaths, only those due to acute poisoning should be notified to the coroner. Deaths due to natural chronic/long lasting conditions (caused by alcohol or cigarette consumption) should not be notified to the coroner.

The death was due to exposure to, or contact with a toxic substance

10. This applies to any cases where death was due to the exposure to a toxic substance. Examples of this include, but are not limited to deaths due to:
    - Toxic material, including toxic solids, liquids and gases.
    - Radioactive material.

The death was due to the use of a medicinal product, the use of a controlled drug or psychoactive substance

11. This applies to deaths due to either the deliberate or accidental intake or administration of medicinal products or any other drugs, or any complications arising from this. Examples of this include, but are not limited to:
    - Illicit, or recreational drugs.
    - Medical drugs, including but not limited to, prescribed or non-prescribed medication (e.g. a self-administered overdose or an excessive dose given either in error or deliberately).

12. Any circumstance where the death may be due to a psychoactive substance should be notified to the coroner. A psychoactive substance includes any substance which is capable of producing a psychoactive effect in a person if, by stimulating or depressing the person's central nervous system, it affects the person's mental functioning or emotional state. Examples of this include, but are not limited to:
    - New psychoactive substances, also known as 'legal highs' or 'designer drugs'.
    - Herbal highs, such as salvia.

The death was due to violence, trauma or injury

13. A death may be considered due to violence, trauma or physical injury where, for example, the deceased:
    - Died as the result of violence, trauma or injuries inflicted by someone else or by themselves.
    - Died as the result of violence, trauma or injuries sustained in an accident, such as a fall or a road traffic collision.

The death was due to self-harm

14. This may apply if it is reasonable to suspect that the deceased died as the result of poisoning, trauma or injuries inflicted by his/herself or his/her actions.

The death was due to neglect, including self-neglect

15. Neglect applies if the deceased was in a dependent position (e.g. a minor, an elderly person, a person with a disability or serious illness) and it is reasonable to suspect that there was a failure to provide them with – or to procure for them – certain basic and obvious requirements. This would include, for example, a failure, omission or delay by any person to provide or procure:
    - Adequate nourishment or liquid.
    - Adequate shelter or warmth.
    - Adequate medical assessment, care, or treatment.

16. This also includes a death, albeit from natural causes, where it is reasonable to suspect that the death results from some human failure, including any acts/omissions.

17. Self-neglect applies if the death is a result of the deceased intentionally or unintentionally not preserving their own life. However, this does not include circumstances where there has been a documented, reasonable and informed decision by the deceased not to act in a way that would have preserved their own life. This may include a decision not to take a certain course of treatment.

18. There may be cases where people fail to take adequate nourishment or proper personal care due to the natural progression of an underlying illness, such as dementia. Although this may hasten their death, this death should not be notified to the coroner unless there was neglect by others.

19. It does not extend to deaths where the lifestyle choices of the deceased – for example, to smoke, eat excessively, or to have a chronic alcohol condition – may have resulted in their death.

The death was due to a person undergoing any treatment or procedure of a medical or similar nature

20. This applies if the death may be related to surgical, diagnostic or therapeutic procedures and investigations, anaesthetics, nursing or any other kind of medical care. It includes scenarios such as:
    - Death that occurs unexpectedly given the clinical condition of the deceased prior to receiving medical care.
    - Errors made in the medical procedure or treatment e.g. the deceased was given an incorrect dosage of a drug.
    - The medical procedure or treatment may have either caused or contributed to death (as opposed to the injury/disease for which the deceased was being treated).
    - Death follows from a recognised complication of a procedure that has been given for an existing disease or condition.
    - The original diagnosis of a disease or condition was delayed or erroneous, leading to either the death or the acceleration of the death.

21. It should be noted that a death that has occurred following a medical or similar procedure may not necessarily be due to that treatment; the medical practitioner should consider whether there is a relationship. It is only in circumstances where the medical practitioner believes that the death was due to this procedure that the death should be notified.

The death was due to an injury or disease attributable to any employment held by the person during the person's lifetime

22. This includes injuries sustained in the course of employment (including selfemployment, unpaid work, work experience or contracted services), for example if the death was due to a fall from scaffolding, or being crushed in machinery. It also includes deaths that may be due to diseases received in the course of employment even if the employment has long ceased.

23. Diseases in the course of employment made include, for example:
    - A current or former coal miner who died of pneumoconiosis.
    - A current or former furniture worker who died of cancer of the nasal sinuses.
    - A current or former construction worker who died of asbestos-related lungdisease e.g. asbestosis or mesothelioma.
    - A current or former rubber or paint worker who died of bladder cancer

The person's death was unnatural but does not fall within any of the above circumstances

24. A death is typically considered to be unnatural if it has not resulted entirely from a naturally occurring disease process running its natural course, where nothing else is

implicated. For example, this category includes scenarios in which the deceased may have contracted a disease (e.g., mesothelioma) as a result of washing his/her partner's overalls which were covered in asbestos however long before the death occurred.

The cause of death is unknown

25. The duty to notify the coroner of unknown causes of death applies to an attending medical practitioner who is unable to determine the cause of death to the best of their knowledge and belief, based upon a conscientious appraisal of the known facts, including after suitable consultation with colleagues or a medical examiner.

The registered medical practitioner suspects that the person died while in custody or otherwise in state detention

26. This is relevant where the person was compulsorily detained by a public authority regardless of the cause of the death. This applies whether the custody or state detention was in England and Wales or elsewhere and includes:
    - Hospitals, where the deceased was detained under mental health legislation (including instances when the deceased is on a period of formal leave).
    - Prisons (including privately run prisons).
    - Young Offender Institutions.
    - Secure accommodation for young offenders.
    - Secure accommodation under section 25 of the Children Act 1989
    - Any form of police custody e.g. the deceased was under arrest (anywhere) or detained in police cells.
    - Immigration detention centres.
    - Court cells.
    - Cells at a tribunal hearing centre.
    - Military detention.
    - Bail hostel.
    - When the deceased was a detainee who was being transported between two institutions.
    - Any death in which the person would ordinarily have been in state detention but had been temporarily released (for example for medical treatment) or had absconded from detention.

27. This does not include circumstances where the death occurred while the deceased was subject to a Deprivation of Liberty Order unless the person was additionally subject to custody or detention as described at paragraph 25 above.

There was no attending registered medical practitioner required to sign a medical certificate cause of death in relation to the deceased person

28. Only an attending medical practitioner – a registered medical practitioner who attended the deceased during his/her last illness before his or her death – can complete an MCCD, without reference to a senior coroner. Under the Registration of Births and Deaths Regulations 1987, any MCCD that has not been completed by an attending medical practitioner who has seen the deceased either in the 14 days prior to the date of death, or after death, must be reported to the coroner by the Registrar.

29. In hospitals there may be several medical practitioners in a team caring for the patient. It is ultimately the responsibility of the consultant in charge of the patient's care to

ensure that the death is properly certified. In general practice, more than one general practitioner may have been involved in the patient's care and so be able to certify the death.

30. If there is no attending medical practitioner then the death must be notified to a senior coroner. The notifying medical practitioner will need to provide the senior coroner with the relevant medical and supporting information as is known by them.

The attending medical practitioner is not available within a reasonable time of the person's death to sign the certificate of cause of death;

31. If there is an attending medical practitioner who is responsible for signing the MCCD, but this medical practitioner is unable to sign this certificate within a reasonable period, then the death must be notified to the coroner.

32. It is ultimately for the discretion of a medical practitioner to determine what would be a 'reasonable time' based on the individual circumstances of the case. However, it is recommended that where there is an attending medical practitioner, they should be completing an MCCD as soon as possible.

33. It should be noted that a death must legally be registered within 5 days from the date of death, and that the MCCD is needed for such a registration to be made within this time limit. Therefore, the completion of the MCCD must not exceed this time limit.

The identity of the deceased person is unknown

34. If the identity of the deceased is not known, then it follows that there will be no attending medical practitioner and/or the deceased's medical history is unknown, precluding the completion of an MCCD. In this scenario the death must be notified to the senior coroner.

35. Where the identity of the deceased is unknown it is recommended that the death is also reported to the police.

Information to be provided to the senior coroner

Information to be provided to the senior coroner

36. Regulation 4(1) requires the notification to the senior coroner to be made as soon as is reasonably practicable after the medical practitioner has determined that the death should be notified. This will usually be via the office of the local coroner. While the regulations do not prescribe a specific time limit for notifications this notification should be prioritised. If the death arises from an event or occurrence that may be suspicious then the police should be informed immediately.

37. The medical practitioner should usually take reasonable steps to establish the cause of death before notifying the coroner. This may include seeking advice from another medical practitioner, such as a medical examiner or any other responsible consultant. However, where the death is clearly unnatural it may be more appropriate for a notification to be made to the senior coroner straight away.

Written Notifications

38. Notifications in writing include submission of documents by courier or electronically (including email, web portal or other scanning methods). Oral Notifications

39. Regulation 4(2) allows a notification to be provided orally in exceptional circumstances. It is expected that medical practitioners will operate with IT systems which will facilitate the electronic transfer of information and records to the coroner, which includes the scanning of paper records and documents or the creation and transfer of electronically stored records and documents.

40. However, there may be circumstances or occasions where the IT infrastructure or systems required to facilitate the transfer of information, records and documents is not available in order for a timely written notification to be made to the coroner. Where the notifying medical practitioner does not have access to the facilities required to make a notification in written form you should inform the coroner of the reasons for this when making an oral notification.

41. Oral notifications may include notification by telephone.

42. Following an oral notification, the notifying medical practitioner must, as soon as is reasonably practicable provide a written notification, confirming the information given in the oral notification.

The Notification

43. Regulation 4(3) and 4(4) prescribes the information that a medical practitioner must, in so far as it is known to them, provide to a senior coroner when making a notification. If this information is not known to the medical practitioner, they do not have a duty to provide it as part of their notification.

44. Regulation 4(3)(c) requires the medical practitioner to provide to the coroner the name of the next of kin or, where there is none, the person responsible for the body of deceased. Where there is no identifiable person who may be responsible for the body, the medical practitioner should provide the name of the Local Authority who will be responsible for the disposal of the body

45. Regulation 4(3)(d) requires that the medical practitioner indicate the reason why it is deemed that the death should be notified. The Regulations do not specify how this notification should be made and in certain circumstances it may be sufficient to refer simply to the sub-paragraph number within Regulation 3(1). However, it is expected that in most cases, the notifying medical practitioner will provide a detailed explanation of the likely cause of death in narrative form. Where possible, this should include the proposed medical cause of death and an explanation of any technical terms used.

46. Regulation 4(4) requires the medical practitioner to provide any further information that they consider to be relevant to the coroner. It is recommended that the medical practitioner making the notification provides their GMC number in this section. This provision allows for circumstances where a coroner requests medical practitioners to include information relevant to their investigation that is additional to that specifically listed within the Regulations.

47. A coroner's investigation may not be necessary in all notifiable cases. If the senior coroner is satisfied that he/she does not need to open an investigation then he/she may issue a 100A form, or refer the case back to the medical practitioner, who can issue a medical certificate of cause of death. For example, this might happen if the deceased was receiving palliative care

at home, and this was documented in the general practitioner notes, but the general practitioner was unavailable at the time of notification. If this occurs, a clear record should be made in the patient notes by the medical practitioner who notified the death to the coroner, detailing the notification and subsequent re-referral back to the medical practitioner by the coroner.