Pan-Dorset Child Death Overview Panel

Child Death Protocol for sudden unexpected deaths

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1. Foreword

The death of a child is a traumatic time for everyone involved. The family will be experiencing extreme grief, and where the death is unexpected, the family will also be in a state of shock.

Practitioners will need to support the family in understanding what has happened and why.

This protocol deals with sudden unexpected deaths and this is defined as '*not anticipated as a significant possibility, for example, 24 hours before the death, or where there was a similarly unexpected collapse or incident leading to or precipitating the events that led to the death.*' The majority of unexpected child deaths occur as a result of natural causes or accidents and can occur in the home or wider community including hospital, school or other settings.

There is a need to identify where a parent or carer (1) or other individual may have been responsible for a child's death and to fully investigate the circumstances of such deaths.

The interagency response, management and investigation of unexpected deaths in childhood should therefore keep a sensitive balance between the medical management, the care and support of the family and any investigation into the cause of death, including any forensic requirements.

2. Scope

This protocol relates to Dorset Council and Bournemouth, Christchurch and Poole Council, covered by the Dorset Safeguarding Children Partnership and the Bournemouth, Christchurch and Poole Safeguarding Children Partnership. As such all agencies must adhere to it.

It is compliant with Child Death Review: Statutory and Operational Guidance (England) 2018 which sets out expectations of the Child Death Review Process.

The protocol draws on a number of local and national initiatives including the Foundation for the Study of Infant Deaths (FSID), Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (**MBRRACE – UK**), South West Infant Sleep Study (SWISS) together with the current high standard of practice and multi-agency working within Pan-Dorset. This has provided the opportunity to establish good practice and working within clear management strategies, enabling a high quality of service to families.

Working Together to Safeguard Children (2023) states that:
'In making arrangements to review child deaths, child death review partners should establish a structure and process to review all deaths of children normally resident in their area and, as indicated and agreed between child death review partners, the deaths of children not normally resident in their area but who have died there.'[1]

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

The protocol should be considered where there is an unexpected, life-threatening collapse or incident, to secure and preserve evidence or other information, where life is for the time being supported in a hospital environment, but where death is judged to be highly likely. In these cases, the SUDIC protocol will run alongside other safeguarding processes where these are relevant.

The majority of unexpected child deaths occur as a result of natural causes and are

[1] Working_together_to_safeguard_children_2023_-_statutory_guidance.pdf, para 381

an unavoidable tragedy for any family.

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

3. Initial events

In any situation where there is an unexpected death or life-threatening injury, Police should be notified without delay. Police will undertake enquiries of other agencies to ensure that all relevant information is obtained, and, if appropriate, an inter-agency meeting is convened, and this protocol is applied.

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

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

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

4. Forms for Reporting Child Deaths

The online form for Reporting Child Deaths can be found on the online eCDOP system. This is a public facing online page, accessible to all, with no login details required.

5. Overview Flowchart of SUDIC Process

The Overview Flowchart of SUDIC Process can be found in Local Resources.

6. Multi-Agencies Involvement, Discussion and Assessment

Guidelines for individual agencies follow later in the protocol. Individual agencies may have their own detailed guidance to be followed in conjunction with this overarching document.

All cases of unexpected child death need to be referred to the Police. The Police in turn will notify the coroner and the subsequent assessment and management will be carried out in close liaison with the coroner.

The designated Paediatrician for unexpected deaths in childhood will also be informed. The investigation and management of these cases should follow a multi-agency approach, as set out in this protocol.

Where appropriate, a serious incident notification (2) should be made by the Local Authority Lead to the Child Safeguarding Practice Review Panel who will inform the DFE and Ofsted.
Health providers should consider if an NHS serious incident investigation is also needed (notification via risk team of the individual trust).

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

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

The sharing of information between relevant agencies at an early stage following the report of an unexpected child death is vital. It will assist

- In assessing the level of any suspicions; and
- In deciding upon the direction and level of investigation, the practice, the procedures, the timing and the personnel involved in any home visits;
- Ensuring appropriate support for the family; and
- In determining the overall strategy to be adopted.

The Dorset Pledge provides guidance and sets out the legal framework to facilitate the sharing of information.

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

7. Parental Involvement

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

8. Welfare of other Children / Child who has a Life-Threatening Injury, but is Surviving

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

Where the child is surviving, but this protocol is being used, it is essential that alongside any SUDIC investigation, multi-agency planning for the safety and

welfare of the child and any other children is maintained, using, for example, strategy meetings under s47 of the Children Act 1989.

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

Together they will make a decision about which other agencies should be included within an immediate multi-agency case discussion and whether a visit to the place where the child died should be undertaken. This visit should almost always take place for infants who die unexpectedly. The decision about a visit will be made based on the information shared and will be recorded. In general, the involvement of health professionals in scene visits may be of help in considering environments where children have been living and consideration of evidence relating to childc a r e . Most health care professionals have no training in forensic scene investigation and are not able to contribute to the examination of scenes outside of a normal home environment. If health professionals are in any doubt as to whether or not they should take part in a scene visit they should discuss the situation with the designated Dr who may want to liaise with the police before a decision is reached.

Where a visit is to take place, a decision should also be made about how soon (within 24 hours) and who should attend. It is likely to be the on-call CAIT DS and a healthcare practitioner experienced in responding to unexpected deaths. They may make this visit together or separately and then confer (see local child death review protocol). When such a visit is carried out, this will be coordinated by the on-call CAIT DS according to a protocol agreed with the local coronial services and the designated Paediatrician for unexpected deaths in childhood. Detailed guidance re issues to be considered is given in the NPCC
(National Police Chiefs' Council) Rapid Response Record (page 52) but includes the general condition of the accommodation, the detailed consideration of the

sleeping environment, heating and drawer temperature. A video recording of the accommodation should be made. See appendix 1.

A Police Senior Investigating Officer will be appointed who will assume responsibility for the unexpected child death investigation. The SIO will be the specialist child abuse investigation Detective Inspector, the Safeguarding Referral Unit Detective Inspector, CID Public Protection Detective Chief Inspector or, if unavailable, will be the Force on-call senior detective (DI/DCI). The CAIT DS will report directly to the SIO.

After the visit described above, the senior investigating police officer in conjunction with the CAIT DS, visiting healthcare practitioner, GP, health visitor or school nurse, Children's social care, education and or early years provider representatives should review whether there is any additional information that could raise concerns about the possibility of abuse or neglect having contributed to the child's death. This consideration may be in the form of a strategy meeting or planning meeting (joint agency response meeting) and may be by telephone conference or a meeting.

9. Further Case Discussion following Postmortem

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

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

The designated Paediatrician for unexpected deaths in childhood should convene and usually chair a Local Case Review discussion meeting following the final

results of the postmortem examination. The timing of this meeting will vary and may be eight – twelve weeks after the death. The meeting should include practitioners who knew the child and family and those involved in investigating the death. The collection of the core data set should be completed. The purpose of this meeting is to share information to identify the cause of death and / or those factors which may have contributed to the death, and then to plan future care for the family. Potential learning points may also be identified. The meeting may also inform any inquest being held.

If at any point in the investigation / assessment there are concerns about surviving children living in the household see sections 7 and 9.

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

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

10. Working with Loss and Bereavement

A key worker should be identified for the family on the day of the child's death. This will usually be a health professional although there may be occasional situations where it is more appropriate for a police family liaison officer to fulfil the role. The key worker should be a single point of contact for the family for all matters relating to the investigation of their child's death and be able to signpost them to sources of support. Detailed guidance regarding this role is given in Child Death Review: Statutory and Operational Guidance (England) 2018.

NB: Following an expected death of a child families will still need a key worker to support them in the period following the death.

When a child dies out of area there must be a discussion between the child death health leads to agree who will offer bereavement support. This may include a key worker close to home but with meetings with health professionals in the area where death occurred to discuss specific issues e.g. details of medical care provided.

Appropriate health professionals to act as key workers may include:

- Bereavement midwife – for neonatal deaths
- Lead nurse for Child deaths – unexpected deaths of infants and children
- Children's community nurse – children dying of a long-term illness whether the timing of death was expected or not.

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

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

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

All practitioners need to take into account any religious and cultural beliefs that may have an impact on procedures. Such issues must be handled sensitively, but the importance of the preservation of evidence and the elimination of any concerns about abuse or neglect should not be forgotten. There is a cultural reference document available in local resources.

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

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

The parents need to be informed that all sudden deaths need to be reported to the coroner immediately and that there may be a need for a postmortem examination.

The coroner may decide to hold an inquest. All investigations into the cause of death need to be conducted under the direction of the coroner.

Parents must be informed about the necessity to carry out all examinations and a postmortem. Where a case is being investigated by the coroner parental consent to a postmortem examination is not required but parents should receive a sensitive explanation of what is involved. This should usually be done by the senior doctor (consultant or registrar level in pediatrics and/or A&E). Some unexpected deaths may be accepted by the coroner as medically explained and the coroner may take no further action – a postmortem would still be desirable but parental consent would then be needed.

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

11. Obtaining and Recording Information

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

Staff from all agencies need be aware that on occasions, in suspicious circumstances, the early arrest of the parents may be essential to secure and preserve evidence. The benefit of arrest for parents is to ensure they are offered the full protection of their legal rights and that they are treated fairly and impartially by the police. The presence of initial suspicion does not qualify as guilt, rather it means that professional concern exists about the circumstances of the death, and this requires a structured criminal investigation.

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

12. Factors which may Arouse Suspicion

Certain factors in the history or examination of the child may give rise to concern about the circumstances surrounding the death. When such factors are identified, it is important that the information is documented and shared with senior colleagues and relevant practitioners in other key agencies involved in the investigation. The following list, whilst not exhaustive, provides guidance:

- **Previous Child Deaths**. Approximately 1 in 2000 children dies suddenly during infancy. Two unexpected child deaths within the same family, whilst very unusual, may be the effect of a metabolic abnormality or other medical abnormality and does not necessarily signify child abuse;
- Previous child protection concerns within the family relating to this child or the siblings or to the adults' contact with other children;
- Inappropriate delays in seeking medical help;
- **Inconsistent Explanations**. The account given by the parents of the circumstances of death should be recorded verbatim. Any inconsistencies in the story given on different occasions should arouse suspicions, although it is important to bear in mind that some inconsistencies may occur as a result of the shock and trauma caused by the death;
- **Evidence of drug/alcohol abuse** - particularly if the parents are still intoxicated. This is more often associated with accidental rather than non-accidental death;
- **Unexplained injury** e.g. unexplained bruising, burns, bite marks. However, it is very important to remember that a child may have serious internal injuries without any external evidence of trauma;
- **Presence of Blood**. The presence of blood must be very carefully noted and recorded. It is found occasionally in cases of natural death. A pinkish frothy residue around the nose or mouth is a normal finding in some children whose deaths are due to Sudden Infant Death Syndrome.
  Fresh blood from the nose or mouth is less common but does occur in some natural deaths. Bleeding from other sites is very uncommon in natural deaths;

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

Guidelines for Individual Agencies

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

13. Ambulance Staff

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

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

Babies who die suddenly and unexpectedly at home should generally be taken to an A&E department unless this is inappropriate. Resuscitation should always be initiated, unless clearly inappropriate and continued until an experienced doctor (usually the consultant on-call Paediatrician) has made the decision to stop. Older children will also generally be taken to A&E unless this is inappropriate.

Exceptions to transfer to A&E for all age groups include:

- circumstances of the death require the body to remain at the scene for forensic examination
- cause of death involves severe trauma and / or disfigurement
- decomposition of the body

Transfer to the A&E of a deceased child is to allow for examination of the child's body with documentation of any external marks or injuries that may be evident and to allow the family to spend time with their child. In cases of unexpected death, it may not be possible for the family to spend time with their child if the body has not been examined. Where there are findings to suggest possible inflicted injuries, this may be important information in terms of safeguarding of other children in the family / household and to the police investigative process.

In the situations outlined above it may not be possible for the family to view their child because of the poor condition of the child's body and examination before the postmortem may not be of any benefit (although there may still be the issue of identifying signs of possible injury in some cases). In these situations, the duty of care to clinical staff needs to be considered and it may be more appropriate for the child's body to be taken directly to the mortuary. Where there is any doubt as to what is most appropriate the designated Dr should be involved in the discussions.

When attending a child who has collapsed or may have died Ambulance staff should follow the guidance laid down in the current Ambulance Training Manual as follows:

- Do not automatically assume that death has occurred. Clear the airway and if in any doubt about death, apply full Cardio Pulmonary Resuscitation (CPR);
- Inform the Accident and Emergency (A & E) department of estimated time of arrival and patient's condition;
- Take note of how the body was found;
- Pass on all relevant information to the A & E Department;
- Assess whether any injury is compatible with history given.

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

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

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

14. General Practitioners and Health Visitors

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

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

The practitioner confirming the fact of death should consult the designated Paediatrician for unexpected deaths in childhood at an appropriate time Ideally this should be on the same working day. If out of hours the on-call Paediatrician should be informed, and the Paediatrician Dr will contact the designated Dr if needs be out of hours.

Additional guidance can be obtained from the Lullaby Trust, (formally the Foundation for Sudden Infant
Death (FSID), publication "When a baby dies suddenly and unexpectedly". Whilst this booklet is written specifically for dealing with cot deaths, many of the principles

will apply to other child deaths. Further information is available on the Lullaby Trust website.

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

Members of the primary care team may often be aware of wider background information on the family. This information may help to shed light on the circumstances of the death and may be important to the police in considering any criminal investigation. They will also have a role in considering the welfare of any surviving siblings / children in the household. GPs and health visitors should therefore be prepared to share information on the child and other family members with the Paediatrician and with the Police Investigation team. They should be invited to participate in the strategy discussion held via the MASH. If they are unable to do take part they should ensure that all relevant information has been shared.

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

15. Schools (including Academies, Independent and Free Schools), Early Years, Further Education and other Children's Settings

An ambulance must be called immediately in the event of the sudden death or life-threatening injury to a child that has occurred at the setting. The incident must also be reported without delay by the Head Teacher / Manager to the Police and the parents notified. This SUDIC protocol will be followed alongside incident protocols within the setting. A record of the incident and contact with the police and parents must be made.

Staff dealing with these situations may need support which can be arranged through the staff welfare services. Support for the school/ FE / Early Years community can also be organised by the Education Psychology service. In complex

cases the educational psychologist should be included in the Joint agency response meeting.

16. Hospital Staff in A&E

Immediate Action

On arrival in A&E, the child should be taken to an appropriate area, either the resuscitation room or an area set-aside for such purposes. The senior Paediatrician on call and the senior doctor in A&E should be notified immediately and checks should be made that Police have been notified. Police should also be notified if a child is critically ill, being resuscitated and at significant risk of death where the cause of the collapse is suspicious or unknown as this protocol may need to be followed.

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

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

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

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

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

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

Assessment and investigation

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

A senior doctor (consultant or registrar level in pediatrics or A&E) should take a careful history of events leading up to and following the death of the child. This discussion will be completed in conjunction with the police (usually a CAIT DS).

Detailed guidance about issues to be included in the discussion is given in the NPCC Rapid Response Record page 40. See appendix 2.

The child should be carefully examined, in particular noting any evidence of injury and the state of nutrition and hygiene of the child. Any injuries or rashes should be documented on a body chart. A rectal temperature should be taken immediately on presentation, using a low reading thermometer if necessary. The site and route of any intervention in resuscitation, for example venipuncture or intraosseous needle insertion, needs to be carefully recorded. If the child was intubated the position of the endotracheal tube should be checked by a clinician competent in airway management (not the person that inserted it) before it is removed. Full growth measurements (length, weight and, for children aged 2 years or under, a head circumference) should be taken and plotted on centile charts. Examination for signs of injury / disease should include the skin, mouth, genitalia and retina. Body maps should be used to document all marks noted. If any retinal injury / damage is evident an ophthalmologist should be requested to examine the eyes if possible. This will generally be requested for all infants dying unexpectedly and is best done within a few hours of death before postmortem changes to the eye make this more difficult. It should be noted that depending on the ophthalmology services in the

acute hospitals and the on call cover it may not always be possible for an eye examination to be undertaken.

All drugs administered during resuscitation must be documented.

Detailed guidance about the expected examination of the body and body maps are given in the NPCC Rapid Response Record pages 21-33.

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

In **rare** cases of highly suspicious deaths it may be appropriate for imaging to be undertaken urgently in the receiving hospital and may include CT head, skeletal survey and / or MRI of torso if clinically indicated. This will need to be agreed by police, coroner, designated Dr. or consultant Paediatrician and consultant radiologist. Information obtained from such investigations may be key to a police investigation and will be relevant to safeguarding decisions regarding other children in the family / household. Such investigations require specialist radiography staff who may not be available, and it may not be possible to undertake the tests. It is usual practice for sudden unexpected deaths in infancy / very young children to take photographs of the child along with prints of the hand and foot and a small lock of hair as mementoes for the family. If this is done it must be with the consent of the parents and clearly documented in the notes.

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

Arrangements for Children's social care to be contacted by telephone regarding information held, including those children who are the subjects of Child Protection

plans, will be made by the Senior Investigating Police Officer. This information will include anything known about all other members of the household. The fact that child and / or siblings' names are not known to Children's social care does not exclude the possibility of child protection concerns.

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

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

Family Support

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

It is important that all staff are familiar with the principles and general guidance of this protocol.

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

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

The family should be informed that the death must be notified to the Coroner, and that a post mortem will be required. Unless there is an obvious cause of death, it is

usually best to say that an opinion cannot be given until after the post-mortem examination. Explain to the family sensitively what a postmortem involves. Ensure that the family know where this will be done and that it is likely to be at a specialist centre, but that the child will be returned after the postmortem.

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

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

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.

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

Further Management

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

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

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

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

Where the death occurred in a hospital, the NHS England Serious Incident Framework (2015) should also be followed.

All families should be visited at home within 24-48 hours by the Health Visitor and/or General Practitioner or, on some occasions, the Paediatrician, to assist the family in coping with the loss of a child. There must, however, be liaison with the police SIO and / or CAIT DS prior to any contact to avoid duplicating visits and to ensure inappropriate questions are not asked about the circumstances of the child's death.

17. Police and Coroner's Office

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

Neonatal deaths are those occurring in the first 28 days of life. The vast majority of neonatal deaths occurring while the newborn infant is still in hospital are medically explained. In the rare circumstance that there is concern about events leading to such a death the concerns should be discussed with the coroner and the police as appropriate. Neonatal deaths occurring after discharge home should be managed

as a sudden unexplained death in infancy but there is an increased likelihood that a medical explanation for the death will be identified.

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

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

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

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

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

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

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

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

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

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

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

- Retention of bedding and items such as the child’s used bottles, cups, food, medication which may have been administered. This may be influenced by obvious signs of forensic value such as blood, vomit or other residues. Items should be retained only after the scene has been assessed and recorded by the police;
- The child’s nappy and clothing should remain on the child but, if removed, arrangements should be made for them to be retained at the hospital;

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

The issues of continuity of identification must be considered. The child should be handled as if he/she were alive

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

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

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

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

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

different police officers should be avoided at this stage. Joint working with other agencies is essential.

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

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

Where the death occurred in a custodial setting, appropriate liaison should occur with the investigator from the Prisons and Probations Ombudsman.
Specialist police teams may be involved in specific circumstances e.g. Traffic police for road traffic incidents or British Transport police for deaths occurring in relation to railways.

18. Children's Social Care

In all cases of unexpected child death, or a life-threatening injury to a child, the Children's Social Care duty team or Out of Hours Children's Social Care will be contacted by the Police for any information they may hold about the child and/or family. A tripartite (health, children's social care and police) Rapid Response discussion will always take place and will clarify if there is information held by Children's Social Care concerning the family or child who has died. This meeting will generally be convened by the health child death lead; for Dorset Council please refer to Scheme of Nomination and Delegated Authority relating to level of manager who should attend on behalf of Children's Social Care. The MASH health team

should collate information available to them. Where there are other children of the family / household their welfare must also be considered.

See Rapid Response flow chart and Appendix 4 for the meeting agenda and template for documentation.

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

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

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

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

- Whether and how Section 47 enquiries in relation to other children should proceed;
- What protective measures are required in the meantime;
- Whether legal action is appropriate;
- Contingency plans in case the situation changes;
- What information is to be provided to parents and/or family members;
- How SUDIC procedures will work alongside s47 investigations, and how they will maintain information sharing.

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

- Whether a senior officer in Children's Social Care needs to consider notifying **the National Child Safeguarding Practice Review Panel of the death as a serious incident notification and thus trigger an LSCB multi-agency Rapid Review to consider the need for a review of the case. In a situation where insufficient information is available to make this decision conclusively, a review point should be set for when more information is available**.
- Notifying the Dorset Clinical Commissioning Group (CCG) as a requirement of the Serious Untoward Incident Reporting protocol;
- What information should be provided to which staff;
- Whether the staff who previously dealt with the family, or are to deal with them in future, are likely to need additional support.

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

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

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

In some situations, particularly the unexpected death of an adolescent, it may be necessary to consider the welfare of the young person's peer group and community safety. **Operation Passkey** may be implemented in such circumstances and is a multiagency process for identifying vulnerable young people in need of support. See appendix 3.

19. Coroner / Pathologist and Post Mortem

After the death is pronounced the Coroner has control of the body. Medical samples other than those described above should not be taken without the consent of the coroner and all samples taken must be clearly documented in the medical records. Mementoes such as photographs of the child, hand and foot prints and a small lock of hair may be taken with parental consent and with prior consultation with the coroner. All mementoes taken should be recorded in the medical records.

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

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

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

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

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

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

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

If the results of any investigations suggest evidence of abuse or neglect as a possible cause of death whether at home or in the community, all practitioners should inform relevant safeguarding partners and the panel immediately.

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

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

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

The Coroner has a duty to share information, including post-mortem reports with the relevant child death review partners.[2]

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

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

Any information from the radiologist or from other examination or tests e.g. toxicity, which indicates the possibility of child abuse, even if not conclusive, must be conveyed to the investigating police office immediately. This will allow the multi-

[2] Coroner’s duty to share information, including post-mortem reports with the relevant child death review partners, p.149

agency re-assessment of any potential risk to other children, in the light of this new information.

20. Child Death Overview Panel

Child Death Review: Statutory and Operational Guidance (England) 2018 sets out the processes to be followed when a child dies in the area of a Child Death Review Partnership. Local death reviews remain the responsibility of the individual Local Authority. Pan-Dorset and Somerset have agreed to work together to jointly provide Child Death Overview Panel (CDOP) as detailed in the Pan-Dorset and Somerset Terms of Reference, which is in keeping with national guidance.

An overview of all child deaths in Dorset, Somerset, Bournemouth, Christchurch and Poole council areas will be undertaken by the Pan Dorset and Somerset Child Death Overview Panel (three Child Death Review Partnerships). This is an exercise, based on information available from those involved in the care of the child and other sources as appropriate who meet at the Local Case Review.

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

The Child Death Review Partnership should decide who will be the designated person to whom the death notification and other data on each death should be sent. The contact details of the nominated person can be found in the **Procedures Local Contact Directory**. The Overview Panel is responsible for ensuring that this process operates effectively.

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

21. Conclusion

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

- Use sensitivity with family members and colleagues;
- Have an open minded / balanced approach;

- Deliver an inter-agency response;
- Share information appropriately;
- Respond appropriately to the circumstances;
- Preserve evidence;
- Identify needs in relation to diversity and provide for them, e.g. using an appropriately skilled interpreter or communicator;
- Use knowledge of best practice in working with loss and bereavement.

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

References

1. Child Death Review: Statutory and Operational Guidance (England) 2018 Department of Health and Social Care and Department for Education

2. National Police Chief's Council, Rapid Response Record, Child death investigation booklet. Sudden unexpected death of children under 18. Version 1 5.7.16, D/Supt. V Dennis - Hampshire

Appendix 1: Home visit and assessment

National Police Chief's Council Rapid Response Record. Child Death Investigation Booklet.
Page 52

OBJECTIVES:

Preferably within 24 hours there will be a joint visit to the home by a Health Responder and the Police. If a rapid response is required on a child who had complex needs/disabilities a Paediatrician may be required as part of the rapid response. The rapid response team will talk to the parents and examine the place where the child died (which may not be at the home) and gather more information

If the death is considered suspicious no home or scene visit will be conducted without prior authority of the SIO.

1. The parents should be made aware that a home visit will be required. Prior to the visit the Police and Paediatrician should decide who should perform which role during the home visit (i.e. document what is said or speak with the parents). This is also an opportunity to update the Paediatrician if they have not been at the hospital.
2. It is good practice in a non-suspicious death for the Paediatrician to take the lead in speaking with the family and the Police to document what is said. Both should sign the record. A copy will be provided to the other agency ASAP after the visit.
3. Introductions to be made to those at the premises and explanation of the need for the visit if not already done and the role of each professional.
4. Offer support to the family and ensure they have the contact details from page 37.
5. Use the history obtained to decide which rooms would be most appropriate to visit first. Be led by the wishes of the parents whenever possible and allow them to explain in their own time showing you around the address.
6. If there is medical equipment being used by the child consider removal to the supplying hospital to check its functioning. Note rapid response nurse are unlikely to have the expertise in this area.
7. Consider that if the death becomes suspicious a full record should be retained of what is said and action taken during the home visit and this should be fully documented within the child death booklet.
8. Consider whether a scene of crime officer is required to attend to photograph the home or provide other expert advice. Note they are generally in uniform with a marked police vehicle.
9. If not conducted jointly, reasons to be documented.

CONSIDERATIONS

- Try to ensure the scene is left undisturbed until the visit takes place.
- Forensic considerations including scene security and preservation of evidence.
- Joint police and rapid response nurse where possible.
- If joint visit not possible rapid response nurse and SIO to liaise closely to ensure consistency, share findings and discuss their interpretation.

SEMI-STRUCTURED INTERVIEW

- Allow parents to cover narrative in their own time and order.
- Is account consistent?
- Does account match scene and timings?

HOME

- Use camcorder to visually record layout & different angles of the room
- Observe full height of the room
- Overall layout of the room: surroundings and content; heating; windows
- Position of bed/cot in room in relation to walls, furniture, radiator etc.
- Appearance of bed/cot: size; bed clothes; other objects on the bed; unusual findings
- How is the bed covering folded
- Description of sleep – how and where baby put down; how and where found

GENERAL OBSERVATION, TEMPERATURE AND ROOM MEASUREMENTS

- Size, orientation, general appearance and layout
- Any unusual or unexplained features.
- Drawer temperature.
- Condition of the accommodation, general hygiene and cleanliness, safety issues, availability of food, adequacy of clothing, bedding etc.
- Sketch plan

OTHER

- Following home visit & death scene investigation -further
  Review any significant concerns regarding abuse/neglect, which may have contributed to infants' death.
- If significant concerns Police may review and consider criminal investigation
- Parental support
- Explain post mortem and rapid response procedure

Appendix 2: History of events from parents/carers – to cover in full the previous 24 hours

National Police Chief's Council Rapid Response Record. Child Death Investigation Booklet, p.40

The below should be used as an aide memoir of questions to consider and not as an exhaustive or definitive list.

IF NOT RECORDED ABOVE THEN ASCERTAIN:

FAMILY BACKGROUND • Parental details, age, occupations, smoking and drugs, family history of cot death or other conditions • Other children	BACKGROUND HEALTH OF THE BABY • Pregnancy and delivery • Early health, feeding, growth, development, immunisations, temperament • Any illnesses

ASCERTAIN DETAILS OF EVENTS LEADING TO THE DEATH FULL NARRATIVE OF PREVIOUS 24 HOURS

DETAILS OF EVENTS:

- Baby's health and temperament during the previous day.
- What happened? – Include timings.
- Who present and where?
- Movements and actions of carers and others.
- Smoking, drinking, drugs?
- Change(s) in routine.
- What alerted the observer to check the child: whether the baby cried out and if so was the cry normal, was the child observed during the event?
- What was actually observed including whether the infant was trying to breathe struggling/motionless?
- Child sweating?
- Did baby respond to being picked up, slapped on the back or to other intervention?
- Attempted resuscitation?
- When found was baby - blue/white/normal, stiff/floppy, hot/warm/cold?
- Had baby vomited when found?
- Any observed bleeding or other bodily fluids from nose or mouth. • Any unusual findings
- Ambulance called.
- Time from discovery to calling for assistance.
- Resuscitation attempts

CIRCUMSTANCES OF SCENE:

- Time found and by whom?

- Position of body and description of how found. Was this how put down or had the baby moved?
- Had child been moved prior to arrival of other people/professionals?
- Details of blankets, bedding and clothing worn and used.
- Position of cot/bed (which room and position in room).
- Type of heating in premises and room.
- Position of cot/bed in relation to heating.
- Items moved or removed from scene?
- Other witnesses.

SLEEP ROUTINE AND DETAILS OF FINAL SLEEP:

- Time put to bed.
- How put to bed and by whom.
- Position of child when put to bed (include where placed in cot bed).
- Sleeping arrangements (shared bed, own room, shared room etc).
- Last checked and by whom.
- Night-time feeds.
- Last feed (Time and what it was. Was it taken normally)?
- Dummy or propped bottle used?

OTHER:

- Detailed account of child's behaviour 24-72 hours prior to death
- Was an infant intercom in place
- Has anyone visited the household
- Accidents/Incidents during pregnancy for children under 1

Appendix 3: Operation Passkey

Appendix 3: Excerpt taken from the Dorset Police Child Death process

Instances of child death can have a significant impact for members of the community both locally and nationally. There will be substantial ripples felt by individuals who are either involved with the family or who are aware of the circumstances. This extends well beyond individuals who knew the deceased directly and can encapsulate persons within the same peer or age group. In 2007-2008 there were approximately 23 linked suicides of young people within a small geographic area in Wales. The learning from this localised spike in suicides identified many relevant factors including the significance of managing the community impact, enabling appropriate support structures to identify people in need of help and the impact of media reporting on these issues.

The death of a close loved one through suicide is a recognised trigger for like behaviour in persons closely linked to the deceased. Agencies should be mindful that via partners an effective strategy needs to be developed to recognise and mitigate these risks. This will often be best organised via a strategy discussion arranged via the MASH for young people within the family network of the deceased such as siblings/cousins, and then extended to known young people who knew the deceased well such as close friends and boy/girlfriends, as well as relevant adult family members.

Part of the learning from the tragedy in the suicide cluster from Wales related to managing the media reporting of these matters. Investigators and agencies should be very mindful of documenting an effective media strategy in relation to instances of child death. The proactive release of information must be carefully considered and made in conjunction with a reasoned decision that understands and addresses the community impact of the release due to the uniquely traumatic nature of the events. It is common for child deaths to be reported in traditional media outlets as a result of information first circulated on social media by persons outside of the police, particularly in instances of child suicide. It is important that agencies agree on media engagement so that a strategy and subsequent release can be considered, and for contact to be made with the reporting media organisations to attempt to steer the media narrative in a sympathetic and supportive manner for the community.

Child deaths by significantly traumatic incidents or via suicide can have a substantial impact on the community for individuals who both knew the deceased and those that did not. Consideration must be given to the unique circumstances of the events and the individuals who may be exposed to a safeguarding risk as a result. It should be anticipated that in instances of teen suicide or death agencies understand and review the peer group implications of the death to allow for proactive interventions to be made for young people identified as at risk. This should be via a

bespoke multiagency strategy discussion organised through the MASH to identify the social network of the deceased young person and to appreciate all the police and partner information that is relevant. It should be expected that this discussion will result in individuals being tasked to make direct contact with the young people identified as being at risk to provide them with support. These considerations should also be extended to individuals within the wider geographic or peer group, with particular attention paid to the cultural sensitivities from the deceased's specific community.

Appendix 4: Phase 1: Initial information sharing and planning meeting, multi-agency aide-memoire

From the National Police Chief's Council Rapid Response Record. Child Death Investigation Booklet.

INFORMATION GATHERING

- Details of incident history, presentation and examination.
- Comprehensive family history.
- Birth history and previous health of the child.
- Details and health status of any siblings.
- Parental health (physical and mental).
- Previous child protection issues.
- Previous unexplained or unusual deaths in the family.
- Issues of neglect or failure to thrive.
- Previous and/or unusual presentations of the child and/or siblings to medical staff, Ambulance, NHS direct.
- Incidents of domestic violence.
- Parental drug or alcohol misuse.
- Any criminal records of the parents.
- Collation and cross-referencing of multi-agency information in a chronological outline.

CONSIDERATIONS

- What further documentation, exhibits & information need to be gathered & how will this be done?
- Are there are any initial suspicions surrounding the death?
- Are there any child protection risks to other children? (consider formal strategy discussion)
- Co-ordination of approach to the scene and family.
- Co-ordinated bereavement care plan for the family.
- Other important witnesses or people to be seen.
- Notification and compilation of reports for the coroner and pathologist.
- Set date for phase 2 meeting (usually when preliminary PM results expected to be available)

Appendix 5: Child Death Rapid Response Phase One: Initial information sharing and planning meeting

(**WITHIN 24HRS OF DEATH UNLESS A WEEKEND)**

(If considered suspicious death Police SIO will chair all meetings, otherwise Health lead)

Attendance – see contact list Apologies -	Name of child Date of meeting:	Date of Birth: Date of Death:
1 Background to the death	Notes:	Actions -
2 Information sharing about child and family	Notes:	Actions -
3 Safeguarding concerns	Notes:	Actions –
4. Home visit	Notes:	Actions –
5 Media considerations	Notes:	Actions -

6 Who will inform others	Notes:	Actions – 1. Police to inform the paediatrician of the results of the PM.
Date and venue of phase two 2nd strategy meeting (usually when the PM initial results are expected to be available)		send to local CDOP e mail

Appendix 6: Phase One Initial Strategy Contact Sheet

Name	Job title	Email	Mobile	Signature