

1. **INTRODUCTION**

Why the need for protocol?

The majority of unexplained child deaths occur as a result of natural causes and are an unavoidable tragedy for any family. A number of child death reviews have highlighted the lack of guidance for professionals in dealing with the unexplained deaths of children. This protocol is not intended to be prescriptive but endeavours to provide guidance to practitioners who are confronted with these tragic circumstances. It is acknowledged that each such death has unique circumstances and each professional involved has their own experience and expertise, which, quite rightly, is drawn upon in their handling of individual cases. Nevertheless, there are common aspects to the management of unexplained child deaths which it is important to share in the interest of good practice and achieving a consistent approach.

This protocol gives an insight into the priorities of those professionals involved, in an attempt to promote a mutual understanding of each agency's roles and responsibilities. Professionals need to strike a balance between the sensitivities of handling the bereaved families, and securing and preserving anything which may aid them in arriving at an understanding of why the child died.

What is in the protocol?

The protocol contains general advice and guidance in dealing with such deaths along with information concerning inter-agency working. It describes some of the factors which may arouse cause for concern about the circumstances surrounding the death. Finally, there are specific guidelines that provide more detailed information to individual agencies.

The protocol should be applied to all unexpected and unexplained child deaths for children upto the age of sixteen years.

PRINCIPLES

When dealing with an unexplained child death all agencies need follow common principles:-

- Sensitivity, open mind balanced approach
- Recognition of cultural needs
- An inter-agency response
- Sharing of information
- Appropriate response to the circumstances
- Preservation of evidence
- Good record-keeping

2 GENERAL ADVICE FOR ALL PROFESSIONALS WHEN DEALING WITH THE FAMILY

- 2.1 This is a very difficult time for everyone. The time spent with the family may be brief but actions may greatly influence how the family deal with the bereavement for a long time afterwards. A sympathetic and supportive attitude whilst maintaining professionalism toward the investigation is essential.
- 2.2 Remember that all people are in the first stages of grief. They may be shocked, numb, withdrawn or traumatised.
- 2.3 All professionals must record history and background information given by parents/carers in as much detail as possible with signature, time, date and designation entered. The initial accounts about the circumstances including timings must be recorded verbatim.
- 2.4 It is normal and appropriate for a parent/carer to want physical contact with his/her 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.
- 2.5 The child should always be handled as if he/she were still alive, remembering to use his/her name at all times as a sign of respect and dignity.
- 2.6 All professionals need to take into account any religious and cultural beliefs which may impact on procedures. Such issues must be dealt with sensitively but the importance of the preservation of evidence should not be forgotten.
- 2.7 The parents/carers should be allowed time to ask questions about practical issues and be informed where their child will be taken and when they are likely to be able to see him/her again.
- 2.8 Where possible, written contact names and telephone numbers should be given with bereavement information.

- 2.9 In unexplained and unexpected child death cases there is a likelihood that an inquest will be conducted by H M Coroner to establish the cause of death, following a full enquiry by the police and other agencies.
- 2.10 Staff from all agencies need to be aware that on occasions, in suspicious circumstances, the early arrest of the parent/carers may be essential in order to secure and preserve evidence and thus effectively conduct the investigation.
- 2.11 Agency professionals must be prepared to provide statements of fact promptly in the above circumstances.

3 INTER-AGENCY WORKING

3.1 If there are immediate or emerging child protection issues identified at the time of a child's death then all agencies shall follow guidance within the Multi-Agency Child Protection Procedures.

3.2 Where child protection issues are not apparent a strategy meeting will be convened as soon as possible and within seventy-two hours of a child's death (the responsibility of consultant paediatrician with interest in community child health).

3.3 The purpose of the strategy meeting will be:

- For each agency to share information from within case notes / documentation which may shed light on the circumstances leading up to the child's death, including previous child protection issues, previous unexplained or unusual deaths in the family, neglect or failure to thrive, unusual presentations of the child, parental substance misuse, etc.
- To enable consideration of any child protection risks to siblings / any other children living in the household and referral within child protection procedures.
- To ensure a co-ordinated bereavement plan for the family.
- To ascertain whether surviving siblings should be the subject of an enquiry under Section 47 of the Children Act 1989.
- To organise Review Strategy meeting (when all information, including post mortem report, is available).
- To identify appropriate disclosure to the parents.

3.4 Contributors to the strategy meeting will include:

- i) **Health** – The doctor who certified death, the named health visitor for the child, the GP and the designated health professionals (consultant paediatrician with interest in community child health) +/- consultant paediatrician responsible for the child. School doctor and school nurse if school age.
- ii) **Social Services** – The responsible field work manager/team manager or their representative.
- iii) **Police** – The responsible Child Protection Unit or the police officer responsible for investigating a child's death.
- iv) **Coroner** – or representative from the coroner's officer.
- v) **Community midwife** in an appropriate case.
- vi) **Other contributors** may include the ambulance service and education (where the child was attending school, nursery or pre-school).

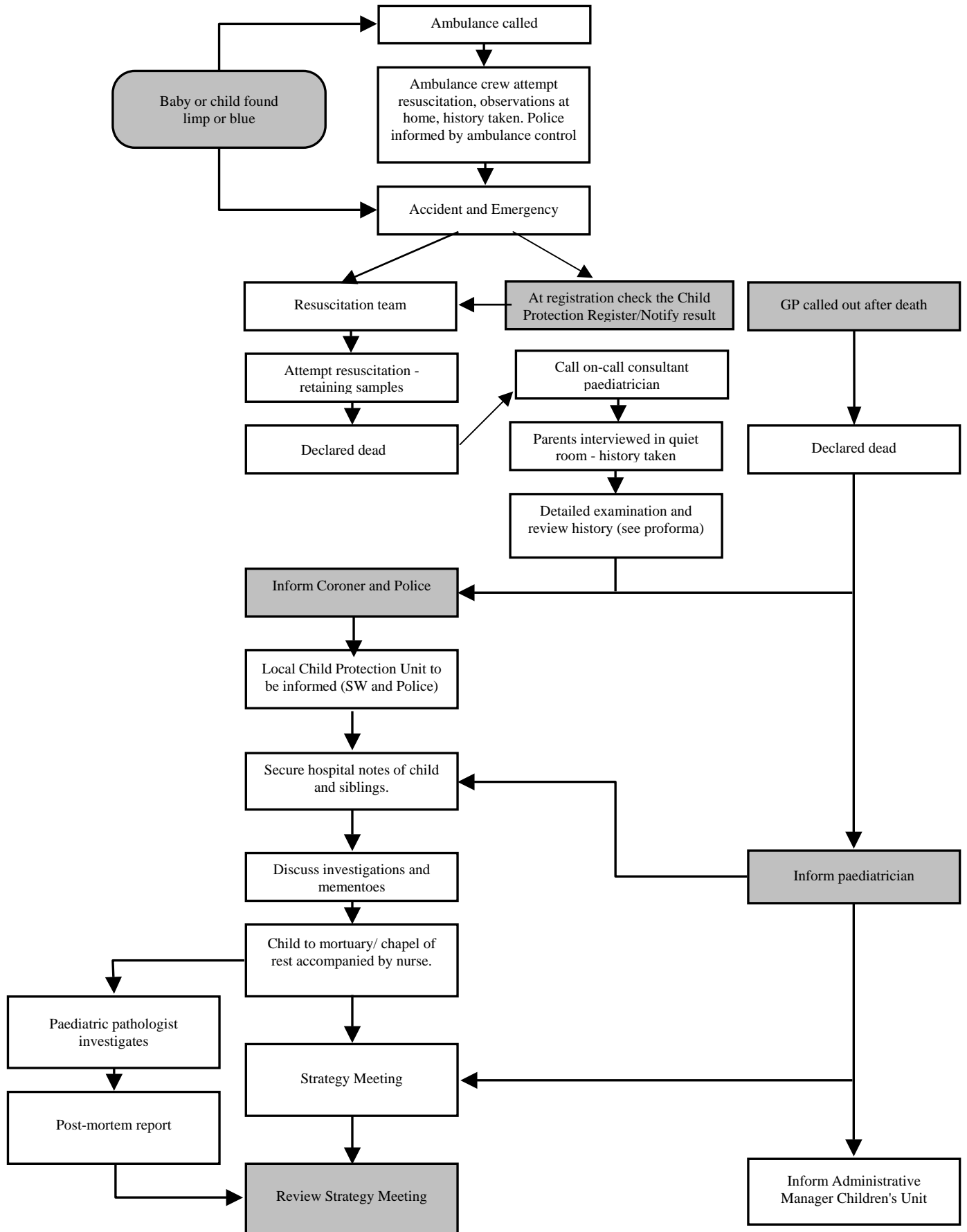
3.5 A Strategy Meeting will require the attendance of Health, Social Services and Police to be quorate.

3.6 A Review Strategy Meeting may be required once all the medical and investigative enquiries have been completed.

3.7 In all cases of unexpected and unexplained child death there will always be a Coroner's inquest. As a result of the strategy meeting or the Review Strategy meeting there could also be: -

- i) Child protection issues – Multi-Agency Child Protection Procedures;
and/or,
- ii) Criminal investigation.

4 UNEXPECTED AND UNEXPLAINED CHILD DEATH (UUCD) (Flowchart summary for children who are dead on arrival or suffer unexpected/unexplained death while in A & E /Acute Unit)



5 AMBULANCE STAFF

- 5.1 Immediate notification to the police is required by the ambulance service when they are called to the scene of an unexplained child death. This will generally be undertaken by the emergency control room contacting the police control room.
- 5.2 The recording of the initial call to the ambulance services should be retained in case it is required for evidential purposes.
- 5.3 Ambulance staff should follow their national training manual as follows:
- Do not automatically assume that the death has occurred
 - Clear the airway and if I any doubt about death, apply full CPR
 - Inform the accident and emergency department giving estimated time of arrival and patient's condition
 - Transport the child to an accident and emergency department or children's hospital if nearer (local arrangements to apply)
 - Take note of how the body was found
 - Pass on all relevant information to the accident and emergency department
 - Ensure that any injury is compatible with history
- 5.4 The first professional on the scene (e.g., Ambulance/GP) should note the position of the child, the clothing worn and the circumstances of how he child was found.
- 5.5 If the circumstances allow, note any comments made by the carers, any background history, any possible drug misuse and the conditions of the living accommodation. Any such information must be passed on to the receiving doctor and the police.

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

- 5.7 Subsequent information should be sought through the clinical manager's office at ambulance headquarters.

6 GENERAL PRACTITIONERS (GPs)

- 6.1 There are times when a GP is called to the scene first. In such circumstances they should adhere to the same general principles as for the ambulance staff (section 5).
- 6.2 It is important for the GP to contact the police or coroner's office if they are the first on the scene (taking into account the primary responsibility of saving life/certifying death). It is advised that the best route for this is to contact the police control room.
- 6.3 If the child died at home, GP must contact consultant paediatrician on call and consultant paediatrician with interest in community child health who will organise the strategy meeting.
- 6.4 The GP and the paediatrician has the responsibility to record the history and background information (refer to proforma) and to share this information at the strategy discussion.
- 6.5 Additional guidance for GP's and health visitors, particularly in relation to the longer term care of the family, can be obtained from two FSID publications:

'Guidelines for GP's when 'cot death' (SIDS) occurs'

and

'Guidelines for health visitors when 'cot death' (SIDS) occur'

Whilst these booklets are written specifically for dealing with 'cot deaths' (SIDS), many of the principles will apply to other child deaths.

- 6.6 The GP will be notified of a Strategy Meeting/Review Strategy Meeting to ensure appropriate representation (section 3).

7 HOSPITAL STAFF

Paediatricians – Accident & Emergency

- 7.1 The identity of the people present and their relationship to the child needs to be ascertained.
- 7.2 If the child is dead upon arrival at the hospital or subsequently dies from an unexplained death, the hospital must immediately check that the police have been notified. Contact should be made with the police area control room where there is 24 hour cover.
- 7.3 The initial examination of the child is extremely important. When the child is brought to the hospital, the consultant paediatrician and A & E consultant should be informed as soon as possible.
- 7.4 A full general examination should be undertaken by the consultant reporting on injuries, rashes and observations about cleanliness of the child, the bedding and the clothing. The examination should include a retinal examination if possible. If any injuries are noted, or concerns identified, the police must be immediately informed.
- 7.5 The detailed history should be obtained as sensitively as possible during resuscitation and as appropriate afterwards. Make detailed records including who is present and what was said.
- 7.6 The consultant paediatrician should obtain background information including a full medical history, a family history, siblings, history of any other infant deaths and concerns regarding this incident or previous incidents. (Proforma for unexpected and unexplained child deaths must be used/will be developed).
- 7.7 Specimens of blood and urine can be taken for metabolic investigations (amino acids, organic acids acyl carnitine profile), toxicology and to exclude infection. The nature of any tests performed must be accurately recorded for the paediatric pathologist. After death is declared consent is necessary for blood and urine specimen.

- 7.8 The site and route of any intervention in resuscitation, for example vena puncture, intra-osseous needle needs to be carefully recorded. Endotracheal tube and intra-venous lines can be removed, however detailed resuscitation procedures, including cardiac massage, cardioversion and the site of lines must be recorded.
- 7.9 Personal mementos should not be taken, or items of clothing or bedding returned to parents/carers until after the initial investigation is complete, and without prior consultation with the coroner and police.
- 7.10 Allow the parents or carers to see and hold their child whilst supervised discreetly by a professional.
- 7.11 Explain to the parents or carers that the coroner has to be informed and that a post-mortem will be necessary to try to discover the cause of death.
- 7.12 The consultant paediatrician should speak directly to the coroner or coroner's officer.
- 7.13 Other professionals also need to be informed and this can be done in liaison with the police officer contacted. Every case should be informed to the administrative manager of the children's unit to notify other departments/professionals involved and cancel all appointments.
- 7.14 A consultant paediatrician should request and review all hospital records of the child and siblings and photocopy prior to release of hospital records. The original should then be released and copy retained by the hospital.
- 7.15 The comments of the parents / carers must be recorded by health professionals in detail in case future discrepancies or suspicious circumstances develop, but specially trained family liaison officers can assist process.
- 7.16 The child's body should not be left unattended until in the mortuary. When the child's body is taken to the mortuary, a professional should be present. It is not essential for the police to undertake this role.

7.17 The consultant paediatrician and the family's GP should together decide on appropriate follow-up consultations.

7.18 Anyone who records in the notes must sign, time, date and put designation/role.

8 POLICE

Who Should Attend?

- 8.1 It is important for police officers to remember that in the majority of unexplained child deaths, the cause has been found to be a natural one. Their actions therefore need to be a careful balance between consideration for the bereaved family and the potential of a serious crime having been committed.
- 8.2 If the police are the first professionals to attend the scene then urgent medical assistance should be requested as the first priority.
- 8.3 Police attendance should be kept to the minimum required. Several police officers arriving at the house can be distressing especially if they are uniformed officers in marked police cars.
- 8.4 Officers should at all times be sensitive when using personal radios and mobile phones, etc. If at all possible, the officers liaising with the family, whilst remaining contactable, should have such equipment turned off.
- 8.5 A substantive Detective Sergeant or above must attend all scenes¹. A Detective Inspector or above must attend the scene if there are any concerns raised by any professional.
- 8.6 An officer from the child protection unit will become involved at the earliest opportunity. Such officers have the necessary skills and knowledge within the field of child protection and inter-agency working.

¹ 'Scene' is referred to in this protocol as the child's home. This is assuming that the child died at home and is still there when the police and other professionals attend. However, on many occasions 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 or more including the child's body, scenes and resources will need to be allocated accordingly. It is important to note that if the child has already been moved from the location where death certified, this does not negate the need for professionals to visit the home and all other scenes.

- 8.7 Family liaison officers will be considered, in line with Wiltshire Police policy.
- 8.8 The coroner's officer must be notified as soon as possible. As well as the usual functions they perform, their experience in dealing with sudden deaths and bereaved families, will be invaluable in explaining to the parent / carer what will happen to their child's body and why. If the coroner's officer asks to attend the scene then this should be allowed in consultation with the investigating officer and family liaison officer. They will also be able to liaise directly with the coroner. The investigating officer and the coroner's officer should continue to liaise closely throughout the investigation.
- 8.9 The Detective Inspector will assess the situation and decide whether it is necessary to immediately consult with a more senior detective or whether such notification can wait.
- 8.10 The senior detective attending will be responsible for deciding on whether to request the attendance of a scene of crime officer (SOCO). Certainly if items are to be removed or photographs or a video are to be taken (see 8.12) then their attendance will be essential.

Initial Action

- 8.11 The provision of medical assistance to the child is obviously the first priority. If an ambulance is not already in attendance then one must be immediately requested unless it is absolutely clear that the child has been dead for some time. If this is the case then a doctor will need to be called to certify death. This will be a police surgeon if there are any overt suspicions as to the cause of death.
- 8.12 The first officer at the scene must make a visual check of the child and its surroundings, noting any obvious signs of injury. It must be established whether the body has been moved and the current position of the infant should be recorded. All other relevant matters should also be recorded. The senior detective attending is responsible for ensuring that this is done in line with national guidelines.
- 8.13 An early explanation from the parent/care is essential. All comments should be recorded. Any conflicting accounts should raise suspicion but it must not be forgotten that any bereaved person is likely to be in a state of shock and possibly confused.

ⁱRepeat questioning of the parent/carer by different police officers should be avoided at this stage if at all possible. All questioning should be done at the direction of the detective inspector, however it is preferable that the fullest history of events is recorded by a paediatrician which will assist officers tasked with investigating the death. Consider audio/video recording this account.

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

Consideration should be given to:

- Commencing a scene log;
 - General preservation of the scene;
 - Arrange for photographs and video of the scene / other rooms, etc;
 - *Retain bedding but only if obvious signs of forensic value such as blood, vomit or other residues;
 - *Retain items such as the child's used bottles, cups, food, medication which may have been administered;
 - *The child's nappy and clothing should remain on the child but arrangements should be made for them to be retained at the hospital.
- *See paragraphs 8.15 and 8.16 below.

The above is NOT an exhaustive list of considerations and should be treated only as a guide. They will be necessary in every case. Refer to the major crime investigation manual for guidance.

8.15 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. Explain that it may help to find out why their child has died. Before returning the items, the parents must be asked if they actually want them back.

8.16 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.

- 8.17 Consideration must be given to evidencing factors of neglect by video or other means which may have contributed to the death such as temperature of scene, condition of accommodation, general hygiene and the availability of food/drink.
- 8.18 A form 65 (report of death form) must be completed at an early stage. This may be completed by the coroner's officer if they are in attendance. However, it may be completed by the investigating officer. A copy of the Form 65 should be sent to the CPU in order to update files.
- 8.19 Additional questions regarding the child's recent health can be recorded on the form 65 under the appropriate heading. These questions should include the basic medical history of the child and family. Other relevant details which are thought to be pertinent to the child's death should also be included. Examples of these could be when the child was last fed, and the food content. A full clinical history obtained by the paediatrician will greatly assist this process.
- 8.20 The issues of the continuity of identification must be considered. This will preferably be done by the coroner's officer but could be done by a police officer and should be carried out appropriately and sensitively. The child should be handled as if he/she were alive.
- 8.21 If the child is certified dead at home, the body will not be transported by ambulance and it will be appropriate to use the services of an undertaker.
- 8.22 If the parents/carers wish to accompany their child to the mortuary, then this should normally be facilitated, ensuring that they are accompanied by a family liaison officer if possible or the investigating officer.

Inter-agency

- 8.23 Police officers need to be aware of other professionals' responsibilities, viz, resuscitation attempts, taking details from the parents, examination of the dead child and looking after the welfare needs of the family. They may need to wait until some of these things have

happened and take details from these professionals before being introduced to the parents. This is where liaison and joint working is essential as there may be evidential reasons why the police need to take urgent action. It is strongly advised that the Child Protection Unit is utilized for such liaison by the investigating officer.

- 8.24 If it is considered that a skeletal survey is required **prior** to the post-mortem, this should be arranged with the paediatric pathologist.

9 CORONERS OFFICER

Paediatric Pathologist/Home Office Pathologist

- 9.1 After the death is certified, the coroners have control of the body and mementoes and medical samples should not be taken without prior consultation with the coroner.
- 9.2 The identity of the pathologist is decided by the coroner in consultation with the investigating police officer and other relevant professional as decided by the coroner, such as the consultant paediatrician. Paediatric pathologists should always be considered alongside home office pathologists.
- 9.3 The generally agreed principle is that if after an evaluation of all the facts there are no grounds for suspecting anything other than a natural death, the post-mortem can be conducted by a paediatric pathologist. If during the post-mortem the pathologist becomes at all concerned that there may be suspicious circumstances, he / she must halt the post-mortem and a home office pathologist contacted.
- 9.4 If the coroner has any concerns, having been made aware of all the facts, that the death may be of a suspicious nature, then a Home Office pathologist will be used in conjunction with a paediatric pathologist.
- 9.5 Both the coroner and the pathologist must be provided with a full history at the earliest possible stage. This will include a full medical history, any relevant background information concerning the child and the family and any concerns raised by any agency. The investigating officer is responsible for ensuring that this is done in consultation with the paediatrician.
- 9.6 The coroners officer must ensure that all relevant professionals are informed of the time and place the post-mortem will be conducted as soon as it is known including parents/carers, Home Office Pathologist, Paediatric Pathologist, SIO, OIC and GP.
- 9.7 The investigating officer should attend the post-mortem. If this is not possible, then he/she must send a representative who is aware of all the facts of the case. A scene of

crime officer must attend all post-mortems conducted by a home office pathologist. The consultant paediatrician should also be invited to attend.

- 9.8 A number of biochemical investigations should be arranged by the pathologist at post-mortem. These include a skeletal survey, if not already taken, swabs, blood, urine, bile and gastric aspirate for toxicology, acyl carnitine profile, amino acids, organic acids and cultures and any other test/sample identified as important by the paediatrician following full case history.
- 9.9 If the paediatrician has arranged any similar investigations before death, the coroner must be informed and the results forwarded.
- 9.10 All professionals must endeavour to conclude their investigations expeditiously. This should include the post-mortem results such as histology. The funeral of the dead infant must not be delayed unnecessarily.
- 9.11 The interim or final findings of the post-mortem should be provided immediately after the post-mortem examination is completed. The interim result may well be 'awaiting histology/virology/toxicology' etc.
- 9.12 The final result must be notified in writing to the coroner as soon as it is known. The final report should then be sent to the coroner within seven or fourteen days of the final result being known.
- 9.13 When a home office pathologist has been used, the pathologist should provide an interim report within two working days of the post-mortem, either orally or in proforma. A full written report should be provided to the investigating officer, normally via the coroner, within 15 days of receipt of the exhibited photographs. Where the scientific examination extends beyond 20 days of the post-mortem, the investigating officer should be informed.
- 9.14 The investigating officer should ensure that a copy is forwarded to the CPT for inclusion on file for future reference. The report must not be shared with other agencies without the permission of the coroner. Permission should always be sought by an agency if the content of the report could potentially affect the agency's future actions.

10 SOCIAL SERVICES

- 10.1 It is important for social workers to remember that in the majority of unexplained child deaths, the cause has been found to be a natural one. Their actions therefore need to be a careful balance between consideration for the bereaved family and the potential of a serious crime having been committed.
- 10.2 Upon notification of an unexplained child death the Duty Manager should cause the checking of the Client Index Register (CIR).
- 10.3 In the event that the family is known to Social Services (case open or closed) the file should be seized by the Duty Manager.
- 10.4 Having seized the file the Duty Manager should ensure that no additional recording or deletion takes place.
- 10.5 Subsequent recording should be kept on a new file raised and comply with Section 2.3.
- 10.6 If the family is known to Social Services the Duty Manager should at the earliest opportunity inform the Area Manager/District Manager/Service Manager (Field work) or, in their absence, the Head of Children and Family Services.
- 10.7 The Duty Manager should also inform the principal officer (child protection and quality)/Manager (quality assurance).
- 10.8 In the unlikely event of any individuals being unavailable the Duty Manager must inform the Director of Social Services.
- 10.9 The responsible manager will attend the strategy meeting (section 3).
- 10.10 Any investigation identified by the strategy meeting will be conducted within the multi-agency child protection procedures framework and be carried out jointly as detailed within Section 3 of the child protection procedures.

References

1. Sussex Joint Agency Protocol for unexplained child deaths.
2. SUDI recommendations for sudden unexpected deaths in infancy.
3. Meador R. Unnatural sudden infant death. *Archive Diseases Child* 1999; 80: –14
4. Bacon C.J. Cot death: the responsibilities of the paediatrician. *Current Paediatrics* 2000; 10:92-95
5. Dent A. A study of bereavement care after a sudden and unexpected death.
- 6 Southampton University Hospital's Protocol for unexpected death of a child; 1999.

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Further information can be found in "*Sudden unexpected death in infancy – The report of a working group convened by The Royal College of Pathologists and The Royal College of Pediatrics and Child Health*" (September 2004)
[Hhttp://www.rcpath.org/index.asp?PageID=455H](http://www.rcpath.org/index.asp?PageID=455H)

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